WITH UNFADING INK. Supply every item of afformation carefully. The correct ortant, Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

0.8762
8

MEDICAL EXAMINER'S CERTIFICATE C	OF	DEATH
----------------------------------	----	-------

I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:
COUNTY Carroll MARYLAND	STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give nearest town) (in this place)	OR
TOWN Rural, Westminster   Life	TOWN Rural, Westminster
HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster, Md. R.D.1	STREET (If rural, give location) ADDRESS (Silver Run) Westminster, Md. R.D.1
3. NAME OF (First) (Middle) DECEASED: (Type or Print) Harvey Alvin	(Last)  4. DATE (Month) (Day) (Year)  OF DEATH  DEATH  2 2 19 JJ
Male White WIDOWED, DIVORCED, (Specify):Married Aug	E OF BIRTH:  9. AGE last birthday: IF UNDER I YEAR   IF UNDER 24 HRS.  Months   Days   Hours   Min.
work done during most of work life, even if retired): Farmer, Retired Own farm	Carroll Co., Md. 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Frederick Bankert	Julia Koontz
15. Was Decrased Ever In U.S. Armed Forces? (Yes, no, or unk.) (If Yes, give war or dates of service) 212-24-6461	Harvey L. Bankert R. D. 1, Westminster, Md.
	AL CERTIFICATION INTERVAL BETWEEN
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	og Occlession Onset and Death Ommute
DUE TO	
Antecedent cause(s)  Diseases or conditions if any. (b)	
Diseases or conditions, if any, (b) DUE TO	#
stating underlying cause last (c)	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes \( \text{No } \( \text{D} \)
21a. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   OF street, office bldg., etc CAUSE OF DEATH.	
21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while 1NJURY M. Work \[ \begin{array}{c ccccccccccccccccccccccccccccccccccc	211. HOW DID INJURY OCCUR?
	bed above, held an Autopsy [], Inspection [], Inquiry [], and
	dent □, Suicide □, Homicide □, Undetermined cause □.  CHIEF MEDICAL EXAMINER □ DATE SIGNED
SIGNATURE	DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.
23. BURIAL, CREMATION,   DATE THEREOF   NAME OF CEMETER	
REMOVAL (Specify): 9/25/55 St. Marys C	· · · · · · · · · · · · · · · · · · ·
DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
REG. 9-23-55 Hamit Muller	Althe Non Littlestown, Pa.

VS. A15A - 5 - 53

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#### MARYLAND STATE DEPARTMENT OF HEALTH

8521

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

1. PLACE OF DEATH		<u> </u>		(HOME) OF DECEASED.	
COUNTY Carroll		MARYLAND	STATE Marylar	coun	TY Carroll
CITY (If outside corporate lim OR give nearest town) TOWN Westminst			OR CITY (If outside corpo	rate limits, write RURAL and g	give nearest town)
HOSPITAL OR	W. Main	V	STREET ADDRESS 173	(If rural, give location)	1
3. NAME OF (F	iret)	(Middle)	(Last)	4. DATE (Month)	(Day) (Year)
DECEASED (Type or Print) Jo	hn	Hess	Belt.	DEATH Septemb	er 2P. 19 55
	OR RACE   7	WIDOWED DIVORCED, (Specify) WIDOWED	s. DATE OF BIRTH July 24.1909	1 9. AGE last birthday   If unde	or I year   If under 24 hrs.
10a. USUAL OCCUPATION (Givedone during most of working life, of	ve kind of work evon if retired)	10b. KIND OF BUSINESS OR INDUSTRY Church	II. BIRTHPLACE (State		12. CITIZEN OF WHAT COUNTRY? U.S.A.
Clergyman 13. FATHER'S NAME	•	01:00-01:	14. MOTHER'S MAIDE	N NAME	0.0.4.
John D. B	elt		Effie Hess		
15. WAS DECRASED EVER IN U.S.	ABMED FORCES?	16. SOCIAL SECURITY NO.	17. INFORMANT AND	ADDRESS	
(Yes, no, or unknown) (II yes, gives, yes, yes, gives)	NW2 or dates of	none	Mrs. Effie Bel	Lt, Westminster; 1	Maryland
		18. MEDICAL CE			
590 X Immediate cause	(a)	Reute Con	rebral He	enombogs	ONSET AND DEATH
Antecedent cause(s Diseases or conditions, is giving rise to the above	any, (b)	Deste "	ephrities		7 days.
stating the underlying ca	(c)				+
II. OTHER SIGNIFICANT COL Conditions contributing to the related to the disease or conditi	death hut not				
19a. DATE OF OPERATION	19b. MAJOR FL	NDINGS OF OPERATION			20. AUTOPSY?
					Yes D No D
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE OF INJUR	E (Home, larm, factory, street, office bidg., etc.)	(CITY OR	TOWN) (COUNTY	Y) (STATE)
TIME (Month) (Day) (Y		NJURY OCCURRED While at Not While	HOW DID INJURY OF	CCUR?	
OF INJURY		Work At work	10.75.00	/	
			10 St. 91.	37 10 1	
22. I hereby certify that I	attended the	deceased from 7/2/	, 19 J. to	7.2, 19. J., that I last	saw the deceased
alive on 4/22	19 4 0 and	that death occurred at	2 A, m. from the	e causes and on the date s	stated above.
SIGNATURE /	7	(Degree or title)	ADDRESS	1 100	DATE SIGNED
	reelio	LA TUBLE HI	y with	uccester Med.	4/22/50
23. BURIAL, CREMATION I	DATE THEREOF	I NAME OF CEMETE	RY OR CREMATORY	LOCATION (City, town, or cou	
DEMONAL (Specify)	Sept. 24,19			Tanevtown. Marv	
THE PROPERTY OF THE PARTY OF THE	REGISTRAR'S S		24. FUNERAL DIRECT		ADDRESS
REG. A A - C	Hani	1-/ /2//		. Tanevtown. Mar	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

The correct age

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VS. A15

BUREAU Y. S.

SEP 28 1955

DECENTED

08529

1 8527 CERTIFICATE	E OF DEATH Reg. Dist	No. 74
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	D:
COUNTY MARYLAND	STATE MICH COUNTY	uy
CITY (If outside corporate limits, write RURAL)  OR and give nearest town)  Syresville  5 4000 8 400	CITY(If outside corporate limits, write RURAL of TOWN Bell'unde 1	P 3101,4
15 INSTITUTION OR Springfield State Hospital	ADDRESS 307 E. Lorrain	1
3. NAME OF DECEASED: (Type or Print) Harold Caywood Bots	spord of DEATH: 9	Day) (Year) 4 1955
male 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married 4/7	101   37 yrs.	Days Hours Min.
Work done during most of working life. even if retired): Laborer 108. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): 12.  W. S. A, New Y & R.	COUNTRY?
Manson Botsford	Mayra Caywood	
(Yes, no, or unk.) (If Yes, give war or dates of service) 11. Social Security No.	Hospital records	
18. MEDICAL CERTIFICAT	ION	INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
025 IMMEDIATE CAUSE (A) Cerebral	l Hemorrhage	12 days
ANTECEDENT CAUSE (8) DISEASES OF CONDITIONS, IF ANY.  (B)  Sy My 4: 4	- mengues encephalitis	Vears
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	D0 +000	1/1
(c) ALLASTED	Pulmonay Tarofatosos	less
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	mis due to syphilite menery	
194. DATE OF OPERATION:   198. MAJOR FINDINGS OF OPERATION	V	20. AUTOPSY?
2		YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	etc. INJURY OCCUR?	ty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While At work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7/1/ alive on 9/4, 1955, and that death occurred at	//20 PM, from the causes and on the date	stated above.
holung m. du, 1	.D. Syresvice   min	7/4/22
Burial Sept 6 1955 NAME OF CEMETE Sept 6 1955	ERY OR CREMATORY   LOCATION (City, town, o	r'ebunty) (State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	William Dukner 1	address Patre

- 10 - 53 A15-VS. PLEASE TYPE OR WRITE PLAINLY, WITH

MARGIN RESERVED FOR BINDING

SEP 9 1955

17/17/18

08530

8528

#### 2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 7 8

I. PLACE OF DEATH. 2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY STATE Carroll Maryland MARYLAND CITY (If outside corporate limits, write RURAL and OR givo nearest town). LENGTH OF STAY CITY (If outside corporate limits, write RURAL and give nearest town) OR givo nearest town)
TOWN RUTE1 this place) Taneytown Rural Tanevtown TOWN HOSPITAL OR STREET (If rural, give location) INSTITUTION OR ADDRESS Route #2 STREET ADDRESS 3. NAME OF (First) (Mlddle) (Last) 4. DATE (Month) (Day) (Year) DECEASED (Type or Print) Mahlon Theodore Brown DEATH September 19 55 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married 6. COLOR OR RACE 5. SEX 8. DATE OF BIRTH 9. AGE last birtbday | If under 1 year | If under 24 hrs. | Months | Days | Hours | Min. Male White July 10, 1873 10b. KIND OF BUSINESS OR 10s. USUAL OCCUPATION (Give kind of work 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT done during most of working life, even if retired) Own Farm COUNTRY? U.S.A. Maryland Farmer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME John Brown Mary Eicholtz 17. INFORMANT AND ADDRESS 15. WAS DECRASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes, give war or dates of 220-03-3544 Mrs. Mahlon Brown, Taneytown, Maryland 18. MEDICAL CERTIFICATION INTERVAL BETWEEN I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY Ceolinal Obstruction No P 21. ACCIDENT PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (Specify) (STATE) SUICIDE HOMICIDE INJURY INJURY OCCURRED HOW DID INJURY OCCUR? TIME (Month) (Day) (Year) (Hour) While at Not While INJURY Work At work 1940, to 4/18, 1955, that I last saw the deceased 22. I hereby certify that I attended the deceased from / 0 and that death occurred at ADDRESS no the causes and on the date stated above. alive on ..... (Degree or title) DATE SIGNED DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) 23. BURIAL, CREMATION Sept. 20.1955 Latheran Cemetery Taneytown, Maryland 24. FUNERAL DIRECTOR DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE ADDRESS rendc.O.Fuss & Son, Taneytown, Maryland

VS. A15
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BUREAU V. S.

8529			111101411, 10	100001
0043	CERTIFICATI	E OF DEATH	Reg. Dist.	No. ) 6
1. PLACE OF DEATH:		2. JUSUAL RESIDENCE, (HOME	OF DECEASED:	
	01	Munilar	1 (1).	11
COUNTY (ARTIC	MARYLAND MARYLAND	statelly thus	CCOUN	
OR and give pearest town)	its, write RURAL LENGTH OF STAY	OR (If outside corporate li	imits, write RURAL, an	d give nearest town
1 destination	Jusal Lyears	TOWN Elmon	Kred	al X
HOSPITAL OR INSTITUTION OR STREET ADDRESS	sing Home	STREET ADDRESS	(If rural give location)	
3. NAME OF (First)	(Middle)	(Last) 4. DATE	(Menth) (Day)	(Year)
(Type or Print) ANNIE	- 1/1/	FINGTON OF DEATH	1 1	19 55
5. SEX:   S. COLOR OR	7. SINGLE, MARRIED,   8. DATE		birthday: IF UNDER 1 YE	
RACE:	WIDOWED, DIVORCED, (Specify):	1- 1072 83	Months Day	ys Hours Min.
10a. USUAL OCCUPATION Give	W July	R   II. BIRTHPLACE (State or fo		ITIZEN OF WHAT
work done during most of work	ing life, INDUSTRY:	II. BIRTHPLACE (State of It	C	OUNTRY?
even if retired);	Le own home	Maryland		4814
13. FATHER'S NAME:	9.	14. MOTHER'S MAIDEN NAME:	,	
Michael	Lippy	Ellen Musers		
15 WAS DECEASED EVER IN U.S. ARMI (Yes, no, or unk.) (If Yes, give war service)	ED FORCES # 187 SOCIAL SECURITY No.: 17	INFORMANT & ADDRESS:	- Westnesses	ter ned
7 2700	18. MEDICAL CERTIFICAT	ION TO THE PARTY OF THE PARTY O	- 00000000	
I. DISEASES OR CONDITIONS  33/X Immediate cause  Antecedent causes (s) Diseases or conditions, if any giving rise to the above cause	(a) leubr DUE TO Sterio	of Kennoge Schrosis	•	Onset And Deat  3 days
stating the underlying cause la	(c)			
11. OTHER SIGNIFICANT CONDI- Conditions contributing to the c related to the disease or conditi	TIONS leath but not			
19a. DATE OF OPERATION: 19b	. MAJOR FINDINGS OF OPERATION			20. AUTOPSY ?
				Yes No
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (S	TATE)
TIME (Month) (Day) (Year) OF INJURY	(Hour)   INJURY OCCURED   While at Not While   Work   At Work	HOW DID INJURY OCCUR?		
22. I hereby certify that I at	tended the deceased from	1955, to 21/2 4, 1	911, that I last s	saw the deceased
	J., and that death occurred at	11 PM, from the cause	s and on the date s	tated above. TE SIGNED
DATE REC'D BY LOCAL REC	ISTRAR'S SIGNATURE	124 FUNERAL DIOCOCOR	rall 60.	ADDRESS
REGISTRAR	A SIGNATURE	24. FUNERAL DERECTOR	F + 1	111

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BUREAU V. S.

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DECENTED

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VS. A15-10-53

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OR
TYPE OR
PLEASE

MARYLAND STATE DEPARTMENT	NT OF HEALTH—BALTIMORE, 18 08529
8530 CERTIFICAT	E OF DEATH Reg. Dist. No.
I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF OECEASEO:
COUNTY MARYLANO CITY (If outside corporate limits, write RURAL) LENGTH OF STA	STATE / MC COUNTY
CITY (If outside corporate limits, write RURAL LENGTH OF STA' (in this place) TOWN Sylves 1 Cle	OR DOA
HOSPITAL OR Shuffield State Hospital  STREET ADDRESS Shuffield State Hospital  MANE OF STREET ADDRESS (Middle)	STREET ADDRESS 4607 WR Road V
3. NAME OF (First) (Middle) DECEASED: (Type or Print)  5. SEX: 16. COLOR OR 17. SINGLE, MARRIED. 18. DATI	(Last) 4. DATE (Month) (Day) (Year) OF DEATH: 9 24 1955
5. SEX:   6. COLOR OR   7. SINGLE, MARRIED, RACE: WIDOWEO, OIVORGED. (Specify): Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired):	11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
IS. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.	Mullion
(Yes, no, or unk.) (If Yes, give war or dates	17. INFORMANT & ADORESS:
18. MEDICAL CERTIFICA	TION INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	ONSET AND DEATH
IMMEDIATE CAUSE (A)	levelit cardio vasinlar disease years
DISEASES OR CONDITIONS, IF ANY. (B)	ed arteros, levos years
STATING UNDERLYING CAUSE LAST.	
(C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING (, )	an with completory disturbance 1100
TO THE DEATH BUT NOT RELATED TO THE CEREBUSE	astero relevosio inte posplistia / ( )
19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES NO
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fa OR CONTRIBUTING CAUSE OF OEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	actory. 21c. WHERE DID (City or town) (County) (State)
2 2 ID. TIME (Month) (Day) (Year) (Hour) 2 1E INJURY OCCURRE While Not while at work	21F. HOW DIO INJURY OCCUR?
22. I hereby certify that I attended the deceased from	20., 1953, to . 9/24, 1955 that I last saw the deceased
alive on 9/24, 1953, and that death occurred a SIGNATURE GENERAL M. Grown, W. D.	M.O. Sylves and on the date stated above.  DATE SIGNED  9 (24/55
23. BURIAL, CREMATION, OATE THEREOF NAME OF CEME REMOVAL (SPECIFY) 9-27-55	TERY OR CREMATORY   LOCATION (City, town, or county) (State)
DATE REC'O BY LOCAL   REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Cless. 25, 1955 C. Harry Eller	Willow tre, 12174 tack to Balo

BUREAU V. S.

SEP 30 1955

VS. A15

MARYLAND	STATE	DEPARTMENT	OF	HEALTH-BALTIMORE,	18
OFOR					

8531 CERTIFICATE OF DEATH

Reg. Dist. No.

												-
I. PLACE O	F DEATH:	+2			2. USUAL RI	ESIDENC	E (HOME	OF DE	CEASEI	0:		
COUNTY	Carrol	1.	MARYI	AND	STATE	Mary	land		C	OUNTY	Cecil	
CITY (If	outside corporate li	mits, write	RURAL LENGTH	OF STAY	CITY (If	outside c	orporate lin	mits, wri	te RURA	L and a	give neare	st town)
X TOWN and	give nearest town)			o days	OR TOWN	Nort	n East			0	7 X -	2
HOSPITAL			24	days	STREET	1102 0		If rural	give loca	ition)	1	1
3 STREET A		nrytor	, Maryland		ADDRESS							
3. NAME OF DECEASED	(First)		(Middie)		(Last)	4	DATE OF	(Mon	th)	(Day)	(Year)	
(Type or Pr					larnes		DEATH:			_5_	19	55
5. SEX:	6. COLOR OR RACE:	7. SING	LE, MARRIED, OWED, DIVORCED,	8. DATE	OF BIRTH:	9.	AGE last h		IF UNDE			Min.
Female	Negro		fy): Widow	4-16-			79	yrs.				
	OCCUPATION. Give		10b. KIND OF BU	SINESS OR	II. BIRTHP	LACE (S	tate or for	reign cou	ntry):	12. CIT	IZEN OF JNTRY?	WHAT
even if re		- ,	III DODIANI		Tenne	ssee				U	. S.	
13. FATHER'S			1		14. MOTHER'S	MAIDE	N NAME:					
	Louis	Rarnes			IIn]	known						
	SED EVER IN U.S. ARM	ED FORCES	16. SOCIAL SECURIT	Y No.: 17.	INFORMANT		ESS:					
(Yes, no, or un	k.) (If Yes, give war service)	or dates of			Elmow Ba	iley	- North	h Eas	t, Ma	ryla	nd	
7			18. MEDICAL CE	RTIFICATIO	ON						Interval	Between
I. DISEASES	OR CONDITIONS	DIRECTL	Y LEADING TO D	EATH								nd Death
Diseases giving ris	ent causes (s) or conditions, if ar se to the above cau ne underlying cause	se	b)									** *** *** *****
		- (	.)							1		
Conditions	IGNIFICANT COND contributing to the the disease or condi-	ITIONS death but	not									
			R FINDINGS OF OF	PERATION						1	20. AU7	OPSY ?
	2										Y es 🔲	No 🗆
21. ACCIDENT SUICIDE HOMICIDE	,	PLA OF INJ	CE (Home, farm, fa office bldg., etc.		(CITY OR	TOWN)		(COUN	TY)	(STA	TE)	
	nth) (Day) (Year)		INJURY OCCUR	ED While Work	HOW DID II	NJURY (	OCCUR?					
	v contify that I a		he deceased from		10 5/1 +=	9_	5 1	9 55	that I	last sa	w the d	eceased
		/			,							
alive on	URE, 19/	22, and	that death occur (Degree or title)	rred at		, from t	he causes	s and o	n the d	DATE	ted abo	ve.
	1.1.11	Ala	6. M. D.		Her	nryton	n, Mary	rland		9-	-5-55	
	L (Specify)	TE THER	1955 Page	F CEMETER	RY OR CREMA	TORY	DAY	ON (City	town	eil (	6	tate)
	C'D BY LOCAL RA	GISTRAR	S SIGNATURE		24. FUNERAL	DIRECT	OR	1 he	The		ADDRES	8
-	יונכרנד		P ( · KIT-Volume	The said	- Vulgari	VIV	un	1	1	a con		

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#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No ...

08534

1. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED COUNTY	01
MARYLAND	July and and	Y
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give pearest sown)	CITY (If outside corporate limits, write RUITAL and giv	e nearest town)
TOWN Town Surface (in this place)	CTOWN AU MUNAC	wal X
HOSPITAL OR	STREET (If rural, give location)	/
INSTITUTION OR UT	ADDRESS WELL ( MUOU)	
3. NAME OF (First) (Middle)	(Last)   4. DATE (Month)	(Day) (Year)
OECEASED TESSE TOSEPH CARTZEI	NAUFNER DEATH At.	V - 156
5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED.	8. DATE OF BIRTH   9. AGE last birthday   If under	
wall wide Widowed, Divorced, Specify our Control	12/29/18/12 85 yrs. Months	Days Hours Min.
10 USUAL OCCUPATION (Give kind of work   10b. KIND OF BUSINESS OR		CITIZEN OF WHAT
done during most of working life, even if retired) INDUSTRY	masuland	COUNTRY?
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
Very Olymon Contract Sheer	Elizabeth Blackster	, ,
15. WAS DECRASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
(Yes, no, or unknown) (If yes, give war or dates of earlies)	& W. Chestrentalier, Cherry	Be Doe Ull
18. MEDICAL CEN	RTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	0	INTERVAL BETWEEN ONSET AND DEATH
	A -4	ONBUT AND DEATH
1 Immediate cause (a) Chronic The	y ocardiles	
Antecedent cause(s) Diseases or conditions, if any, (b) Indiented Meyer	- same curetted out -	220/0
giving rise to the above cause	4	- 00 till de en ee a une un en entimposition anna since de da
stating the underlying cause last	re Tent ou	
II. OTHER SIGNIFICANT CONDITIONS	CCCCCCCC.	1
Conditions contributing to the death but not		
related to the disease or condition causing death.  19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
198. DATE OF OTENATION		
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,	(CITY OR TOWN) (COUNTY)	(STATE)
SUICIDE OF office bldg., etc.)	(000111)	(DIMIL)
HOMICIDE INJURY TIME (Month) (Day) (Year) (Hour)   INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF While at Not While		
INJURY m.   Work  At work		
22. I hereby certify that I attended the deceased from 9-2-	19.55 to 9-18-, 19.57 that I last s	aw the deceased
alive on 9-12-, 19 33, and that death occurred at 8.	ADDRESS	ated above. DATE SIGNED
SIGNATURE: O (Degree or title)	ADDICESS '	DATE SIGNED
V. H degg MA	Muon Durge	A 1.19-51
	RY OR CREMATORY   LOCATION (City, fown, or count	y) (State)
REMOVAL (Specify) 9 21 55 Clurch	Lod Cen. Miontonion.	Ma
DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDRESS
REG. 9/19/33 Leslie L. Kelsto	V. Harmer, & Sous	1
	( (mion) 0/ 0	0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

DECENSED SEE

BUREAU V. S.

#### MARYLAND STATE DEPARTMENT OF HEALTH

8533

2411 N. Charles Street, Baltimore

### CERTIFICATE OF DEATH

70

	Reg. Dist. No
1. PLACE OF DEATH.	2. USUAL RESIDENCE (HOME) OF DECEASED.
COUNTY Carroll MARYLAND	STATE Maryland COUNTY Carroll
CITY (If outside corporate limits, write RURAL and   LENGTH OF STAY	CITY (If outside corporate limits, write RURAL and give nearest town)
X OR givo nearest town) (in this place) Town Tanevtown 2 years	Town Taneytown
HOSPITAL OR	STREET (If rural, give location)
INSTITUTION OR STREET ADDRESS	ADDRESS
3. NAME OF (First) (Middle) DECEASED	(Last) 4. DATE (Month) (Day) (Year)
(Type or Print) John Adam Clagett	DEATH Sept. 17, 1955 19
5. SEX  6. COLOR OR RACE  7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 9. AGE last birthday   If under i year   If under 24 hrs   Months   Days   Hours   Min.
M (Specify) Married	August 30,1883 72 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRY	11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
done during most of working life, even if retired) INDUSTRY OWN farm	Maryland Country? U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John A. Clagett	Annie Hohman
15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
(Yes, no, or unknown) (If yes, give war or dates of none	Mrs. J.A. Clagett, Taneytown, Md.
18. MEDICAL CE	RTIFICATION
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATE
1120.1	6 A
Immediate cause (a) Coronary Car	Clay Ocelusion Ten Min.
D D	1
Antecedent cause(s) Diseases or conditions, if any, (b) Coronary	believes 10 grs.
giving rise to the above cause	**************************************
stating the underlying cause last	
II. OTHER SIGNIFICANT CONDITIONS	alerioclum Elicouis.
Conditions contributing to the death but not	5 17 10 m
related to the disease or condition causing death.  19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATION	1 20. AUTOPSY?
192. DATE OF OTERATION	
21. ACCIDENT (Specify)   PLACE (Home, farm, factory, street,	: (CITY OR TOWN) (COUNTY) (STATE)
SUICIDE OF office bldg., etc.)	(OILL ON TOWN) (OOUNTL) (DIRIE)
HOMICIDE INJURY TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED	HOW DID INJURY OCCUR?
OF While at Not While	IN DID INVOISE COOKS
INJURY m.   Work   At work	
22. I hereby certify that I attended the deceased from 2/26	1955 to 9/17 1955 that I last saw the deceased
	. K.S. P. m., from the causes and on the date stated above.
SIGNATURI! (Degree or title)	DATE SIGNED
V. S. Mc Vaugh M. S.	Taneylown, man 9/19/55
	RY OR CREMATORY (LOCATION (City, town, or county) (State)
Burial Sept. 20, 1955 St. Davids	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Sett 19/19 5-5+ Ethel M Meaning	C. O. Fuss & Son, Taneytown, Maryland
1 ocal)	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

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8522

## MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

08536

	1. PLACE OF DEATH.	2. USUAL RESIDENCE (HOME) OF DECEASED.	. 1
i	COUNTY CANAL MARYLAND	STATE Manufaced COUNTY	Carrall
	CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) (In this place)	CITY (It outside conforate limits, write RURAL and giv	e nearest town)
	TOWN MASTERNANCE 25210	TOWN Wish Magnetes 17	ad. 27.
	HOSPITAL OR INSTITUTION OR A C. I May	STREET (1) Tural, give location)	1
	INSTITUTION OR STREET ADDRESS Con Many to & Mary land Con	coull lice	/
	3. NAME OF (First) (Middle)	(Last) 4. DATE (Month)	(Day) (Year)
	(Type or Print) CAARLES NESLEY C	ONAWHY DEATH SEPT.	1 122
	6. COLOR OR RACE 7. SINGLE, MARRIED. WIDOWED, DIVORCED.	8. DATE OF BIRTH 9. AGE last birthday II under Months	I year   If under 24 hr Days   Hours   Min.
	William, (Specify)	40M. X, 1893 6 yrs.	
	10a. USUAL OCCUPATION (Give kind of work to the done during most of working life, even if retired) INDUSTRY		COUNTRY?
	13. FATHER'S NAME	Tomorrie (alling a) mi	9.3.4.
	13. PATHERS NAME	14. MOTHER'S MAIDEN NAME	
	16. WAS DECRASED EVER IN U.S. ARMED FORCES? 1 16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
	[ (1es, no, or unknown)] (11 yes, give war or dates of [ ] // A 7 7726.	Maga Che Lichage Light	4. + m1
			usul my
	18. MEDICAL CE	RTIFICATION	INTERVAL BETWEEN
	I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
i	Immediate cause (a) Coronory	Occlusion	nunta
	Immediate cause	***************************************	
	Antecedent cause(s) Diseases or conditions, if any, (b)		
	giving rise to the above cause		
	stating the underlying cause fast		
	II. OTHER SIGNIFICANT CONDITIONS		1
	Conditions contributing to the death but not related to the disease or condition causing death.		
	19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATION		1 20. AUTOPSY?
			Yes 🗆 No 🕅
	21. EXTERNAL CAUSE WAS   PLACE (Home, farm, factory, street,	(CITY OR TOWN) (COUNTY)	100
	PRIMARY OR CONTRIBUTING OF office bldg., etc.) CAUSE OF DEATH.		
	TIME (Month) (Day) (Year) (Hour)   INJURY OCCURRED	HOW DID INJURY OCCUR?	
	OF While at Not while INJURY m, work at work		
	22. I certify that I took charge of the remains described above, held an A obtained by said Autopsy, Inspection or Inquiry, find that said dece	lutopsy , Inspection X, Inquiry V thereon and	from the evidence
	from: natural couses X, occident , suicide , homicide ,	undetermined .	opinion resuited
	SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
	June 7 Thank Deplete Medical Exam	ines - Washingelor Mit	9/1/11
,		RY OR CREMATORY   LOCATION (City, town, or count	ty) _ (State)
	BEMOVAL (Specify)	+ Classet Lysters I	mid
	DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTORY	ADDRESS
	REG. 9-255 Hanut hiller	U.C. mayor & better	t n.O
	- The free free free free free free free fr	1 2 11 your for it william	1111



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 8534

## CERTIFICATE OF DEATH

RE, 18 08537 Reg. Dist. No.

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	D;
COUNTY Carroll MARYLAND	STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL) LENGTH OF STAY		nd give nearest town)
OR and give nearest town) (in this place)	OR	
X TOWN Rural - Sykesville, Md.   1 mo. 26 day		3401-4
HOSPITAL OR	STREET (If rural give location)	
/3 STREET ADDRESS Springfield State Hospital	151 113 N. Decker Avenue	
PROFESOR		Day) (Year)
(Type or Print) William James	COOKE OF DEATH: 9	7 19 55
5. SEX:   6. COLOR OR   7. SINGLE, MARRIED.   8. DATE	OF BIRTH:  9. AGE last birthday 15 UNDER 1	EAR IF UNDER 24 HRS.
Male White Specify: Married 9/2	2/78 77 yrs. Months L	Pays Hours Min.
10A. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS work done during most of working life, OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):  12.	
even if retired);	Manyland	COUNTRY?
13. FATHER'S NAME:	Maryland	UA
William A. Cooke	Margaret Wilson	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates	17. INFORMANT & ADDRESS:	
ano of service) none no	Record, Springfield State Hos	spital
18. MEDICAL CERTIFICAT		INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
491 X	Statement of the Control of the Cont	
IMMEDIATE CAUSE (A) Bronchopnes	umonia	days
ANTECEDENT CAUSE (8)		
DISEASES OR CONDITIONS, IF ANY. (B)		
STATING UNDERLYING CAUSE LAST. DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TOP	pendinted with south busin	
41.000.00	ssociated with senile brain e, with psychotic react.	years?
DISEASE OR CONDITION CAUSING DEATH. Q15885		
135. MASON PINDINGS OF OPERATION		20. AUTOPSY?
21A. ACCIDENT WAS UNDERLYING   21B. PLACE (Home, farm, fac	story 215 WHERE DID (City on town) (Course	(\$4-4-)
OR CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)		(State)
21D. TIME (Month) (Day) (Year) (Hour)   21E INJURY OCCURRED	D   21F. HOW DID INJURY OCCUR?	
OF INJURY  OF INJURY  OF INJURY  OF INJURY  OCCURRED  While Not while at work at work		
22. I hereby certify that I attended the deceased from8/22	2, 1955, to 9/7, 19.55 that I last	saw the deceased
alive on 9/7/55, 19, and that death occurred at	9. AM, from the causes and on the date	stated above.
SIGNATURE //		TE SIGNED
Walker of Johnsenally	Sykesville, Md. 9/	77/55
23. BURIAL, CREMATION.   DATE THEREOF   NAME OF CEMET	ERY OR CREMATORY   LOCATION (City, town, or	county) (State)
REMOVAL (SPECIFY)	Cemetery Baltimore, a	
DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08538 Reg. Dist.

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MEDICAL	EXAMINER'S	CERTIFICATE	$\mathbf{O}\mathbf{F}$	DEATH	7

Manual Country of the	THE TOTAL OF THE RO.	
I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY CARROLL MARYLAND	STATE MARYLAND COUNTY GARRETT	
CITY (If outside corporate limits, write RURAL OR and give nearest town)  X TOWN RURAL - SYKESVILLE  LENGTH OF STAY (in this place) 3Y 6M 26 D	CITY (If outside corporate limits write RURAL and give OR TOWN Grantsville //	nearest town)
HOSPITAL OR SINSTITUTION OR STREET ADDRESS Springfield State Hospital	STREET (If rural, give location) ADDRESS	V
3. NAME OF (First) (Middle) DECEASED: (Type or Print) NATHAN	CUSTER   4, DATE (Month) (Day) OF DEATH 9 25	(Year) 19 55
Male White Widowed, Divorced, (Specify): single 2/	3/81 74 yrs. Months Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, INDUSTRY: Farmer if fatherd). U. Messenger Communications	Maryland USA	ZEN OF WHAT
13. FATHER'S NAME: Agriculture	14. MOTHER'S MAIDEN NAME:	
Michael Custer	Maria Ferren	-
15. Was Deceased Ever In U.S. Armed Forces? 16. Social Security No.: (Yes, no, or unt.) (If Yes, give war or dates of service) 212-24-0754	Record, Springfield State Hospital	
Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause DUE TO  DUE TO skull and vetteb  (b)  DUE TO skull and vetteb  (b)  DUE TO skull and vetteb	state with metastases to the unk	ERVAL BETWEEN SET AND DEATH CHOWN
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CHRONIC DO THE DEATH BUT NOT RELATED TO THE CHRONIC DISEASE OR CONDITION CAUSING DEATH. CETEBRAL ATT.	rain syndrome associated with ermosclerosis, with psychosis si	nce 1948?
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:	20.	AUTOPSY?
21a. EXTERNAL CAUSE WAS   21b. PLACE (Home, farm, factory, PRIMARY   or CONTRIBUTING   OF street, office bidg, etc. INJURY NOSDITEAL	Sykesville Carroll Mar	(State) cyland nd from
22. I hereby certify that I took charge of the remains described find that death resulted from: Natural causes, Accidentatives, Accidentatives	ded above, held an Autopsy , Inspection , Inglent , Suicide , Homicide , Undetermine CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.  AT OR CREMATORY LOCATION (City, town, or county)  CE GRATSVILLE, GARRETT	ed cause ATE SIGNED  (State)  (State)  ADDRESS
AEG 27, 1955 C. Herry West	Sonald Newman GRANTSUIL	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

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BUREAU V. S.

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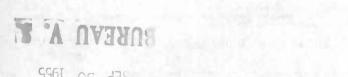
PLEASE TYPE

#### CERTIFICATE OF DEATH

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eg.	Dist.	No.	50

CERTIFICATI	E OF DEATH Reg. Dist.	No. J
1. PLACE OF DEATH: COUNTY CARRELL MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED	rroll
CITY (If outside corporate limits, write RURAL OR and give nearest town)  TOWN  CITY (If outside corporate limits, write RURAL (in this place)	CITY(If outside corporate limits, write RURAL at OR TOWN	nd give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Church St	STREET (If rural give location)  Church St	1
DECEASED: (Type or Print) MARY GOLDIE DA	ANNER OF DEATH: Sept	Day) (Year) 27 1955
RACE: WIDOWED, DIVORCED, Specify):	6-1883 72 yrs. Months Di	ays Hours Min.
work done during most of working life, even if fetired):	11. BIRTHPLACE (State or foreign country): 12.	CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Babylane	Missouria Rinchart	
(Yes, no, or unk.) (If Yes, give war or dates of service) (19 Yes, no. of service) (220-26-0207	Mrs Russell Lambert, new	Window
18. MEDICAL CERTIFICAT	TION	INTERVAL BETWEEN
	inoma Uterus	8 THS.
DISEASES OR CONDITIONS, IF ANY, (B)	emona Uterus	7 yre
STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	N	20. AUTOPSY?
21A. ACCIDENT WAS UNDERLYING OF CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	tory, etc. 21c. WHERE DID (City or town) (County etc. INJURY OCCUR?	y) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from alive on the 26, 19 9, and that death occurred at SIGNATURE	10 p. M, from the causes and on the date s  ADDRESS  DAT  OR Shirmster  DAT	
23 BURIAL, CREMATION. DATE THEREOF NAME OF CEMET.  REMOVAL (SPECIFY)  SULT 30 - 1955  Trivite	ERY OR CHEMATORY LOCATION (City, town, or	md
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	.ADDRESS

VS. A15 -- 10 - 53



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F DEATH:

# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

2. USUAL RESIDENCE (HOME) OF DECEASED

Address strategy	ful	1. PLACE O
RK	arefu	COUNTY
180	0	CITY (If
	nois	Y TOWN
	na ly	HOSPITA
	information clearly and	15 STREET
		3. NAME OF
	m of death	(Type or )
	de	5. SEX:

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TYPE

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OF INJURY

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Carroll STATE Maryland MARYLAND COUNTY Montgomery outside corporate limits, write RURAL| LENGTH OF STAY CITY(If outside corporate limits, write RURAL and give nearest town) d give nearest town) (in this place) TOWN Sykesville Kensington 2 vears LOR STREET (If rural give location) ION OR ADDRESS Springfield State Hospital DDRESS 10700 Montgomery Avenue (First) (Middle) (Last) 4. DATE (Month) (Dav) (Year) DECEASED: Dawson DEATH: Sept. (Type or Print) Virginia 19 6. COLOR OR 17. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE last birthday IF UNDER I YEAR WIDOWED, DIVORCED. RACE: Months Days Hours (Specify): Single IOA. USUAL OCCUPATION (Give kind of) 108. KIND OF BUSINESS 11. BIRTHPLACE (State or foreign country): 112. CITIZEN OF WHAT work done during most of working life, OR INDUSTRY COUNTRY even if retired): Clerk Maryland U.S.A. 13. FATHER'S NAME: 14. MOTHER'S MAIDEN NAME: James Madison Dawson Louise Hebron IS. WAS DECEASED EVER IN U.S. ARMED FORCEST 17. INFORMANT & ADDRESS: (Yes, no, or unk.) (If Yes, give war or dates Hospital records of service) 18. MEDICAL CERTIFICATION INTERVAL BETWEEN I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH IMMEDIATE CAUSE DUE TO ANTECEDENT CAUSE (S: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH CHAPLE 198. MAJOR FINDINGS OF OPERATION 21A. ACCIDENT WAS UNDERLYING 218. PLACE (Home, farm, factory, 21c. WHERE DID (City or town) (County) (State) OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bidg., etc. INJURY OCCUR? (IF EITHER, NOTIFY MEDICAL EXAMINER)

22. I hereby certify that I attended the deceased from 2-19..., 19.53 to 9-12..., 19.55 that I last saw the deceased 9-12 ....... 1955, and that death occurred at 5:45PM, from the causes and on the date stated above. alive on . SIGNATURE DATE SIGNED

21E INJURY OCCURRED

Not while

at work

While

at work

LOCATION (City, town, or county)

BY LOCAL

21D. TIME (Month) (Day) (Year) (Hour)

21F. HOW DID INJURY OCCUR?

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BUREAU V. E.

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#### CERTIFICATE OF DEATH

0000	Reg. Dist	. NO
I. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	C:+
COUNTY Command	STATE Maryland COUN	City
COUNTY Carroll  CITY (If outside corporate limits, write RURAL LENGTH OF STA OR and give nearest town)  MARYLAND  (in this place)	Y CITY (If outside corporate limits, write RURAL a	nd give nearest town)
	OR TOWN	
DAVESATTIE 12 A 2 III ST E		3401-4
HOSPITAL OR INSTITUTION OR	STREET (If rural give location	,
5 STREET ADDRESS Springfield Sate Hospital	3132 Harview Avenue,	V
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) (Day	(Year)
DECEASED:	OF	
5. SEX:   S. COLOR OR   7. SINGLE, MARRIED,   8. DAT	Ruggiero DEATH: 9 10 E OF BIRTH: 9. AGE last birthday: If UNDER 1 Y	
DACE. WIDOWED DIMORGED	Months   D	ays Hours   Min.
F W (Specify) ividowed 2-	21 - 99 56 715.	
to Chear decel Allon dive kind of 100. Kind of Business	OR   II. BIRTHPLACE (State or foreign country):   12.	CITIZEN OF WHAT
work done during most of working life, even if retired:  NOUSTRY:  NOUSEWIFE		nknown
3. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	TIALIUM ZI
D D. Donale		
Benny De Ruggie  15 WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY No.:   1	Fanny Annosico	
Yes, no, or unk.)   (If Yes, give war or dates of	III OMANIE & ADDIVEDO	
unka service) unka	Hospital Records	
18. MEDICAL CERTIFICA		Interval Between
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Onset And Death
525X	1- 11- 111- 2	
	ic interstitial	weeks
Antecedent causes (s)		1.19
Diseases or conditions, if any, giving rise to the above cause (b)		
stating the underlying cause last. DUE TO		
(c)		
		İ
OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not Involutional ps related to the disease or condition causing deathic features,  19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION	sychosis, depressed type with orga-	1
19a. DATE OF OPERATION: 1 19b. MAJOR FINDINGS OF OPERATION	possibly with Fick's disease	20 ROTOFSY ?
		Yes No Y
1. ACCIDENT · (Specify)   PLACE (Home, farm, factory, stre	et.   (CITY OR TOWN) (COUNTY) (S	STATE)
SUICIDE OF office bldg., etc.)	(000111)	,
TIME (Month) (Day) (Year) (Hour)   INJURY OCCURED	HOW DID INJURY OCCUR?	
OF While at Not While	HOW DID INJURY OCCUR?	
THE WORLD		
22. I hereby certify that I attended the deceased from July	18,19.55., toSeptemb.109.55, that I last	saw the deceased
alive on . 9 -10-, 1955, and that death occurred at .	10:25 a.m. from the causes and on the date	stated above.
SIGNATURE (Degree or title)	ADDRESS	TE SIGNED
caverno suchans wi.	Springfield State Hospital 9	20 55
3. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET	ERY OR CREMATORY   LOCATION (City, town, or co	unty) (State)
BURIAL (Specify) 9/13/55 BELAIR N	TEMERIAL BELAIR	MO
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR	24. FUNERAL DIRECTOR	ADDRESS
REMINIAR CC 2 /2/		0 . 11

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct MARGIN RESERVED FOR BINDING

VS. A15

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#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baitimore

08543

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# CERTIFICATE OF DEATH

Reg. Dist. No. 7/

1. PLACE OF DEATH			2. USUAL RESIDENCE (	HOME) OF DECEASE	COUNTY
Carr	~ = =	MARYLAND	STATE Maryland		COUNTY Carroll
OR give nearest	orporate limits, write RUR.; town) niontown	AL and LENGTH OF STAY (in this place)	OR TOWN Union	rate limits, write RURA	L and give nearest town)
HOSPITAL OR			STREET	(If rural, give loc	eation)
INSTITUTION OF	SS S		ADDRESS		
3. NAME OF	(First)	(Middle)	(Last)	4. DATE (Mo	nth) (Day) (Year)
DECEASED (Type or Print)	Hilda	E. D	evilbiss	DEATH Sept	, , , , , , , , , , , , , , , , , , , ,
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED.	8. DATE OF BIRTH		If under 1 year   If under 24 hrs
F	W	WIDOWED, DIVORCED, (Specify) Married	Feb. 3, 1900	55 yrs.	Months Days Hours Min.
10a. USUAL OCCUP.	ATION (Give kind of work	10b. KIND OF BUSINESS OR	11. BIRTHPLACE (State		12. CITIZEN OF WHAT
done during most of w	vorking life, even if retired)	INDUSTRY OWN home	Maryland		COUNTRY U.S.A.
13. FATHER'S NAM		OWN HOME	1 14. MOTHER'S MAIDEN	INAME	0.0.1.
	Franklin E	akand	Carrie S.	Vincling	
15. WAS DECRASED E	VER IN U.S. ARMED FORCES		17. INFORMANT AND	THISTILL	
(Yes, no, or unknown)	(If yes, give war or dates of service)	none	Thomas L. Devi		fra Maryland
110	iservice)	18. MEDICAL CE		TOIDS, UNION	own, mary rana
			RIFICATION		INTERVAL BETWEEN
I. DISEASES OR CO	ONDITIONS DIRECTLY	// "		1	ONERT AND DEATH
2.60 X	(4)	Cerebr	a 0 10111	1256/	20 12 600
260 Ammediate	e cause (a)		a gara	v o a	
Anteceder Diseases or	nt cause(s) conditions, if any, the above cause	Desbetes -	nephriti	sarterer	
stating the u	inderlying cause last			Aclores	es!
	(e)			· October ·	
Conditions contribu	CANT CONDITIONS ating to the death hut not se or condition causing deat	h.			
		INDINGS OF OPERATION			20. AUTOPSY?
0					
2I. ACCIDENT SUICIDE HOMICIDE	(Specify) PLACOF	CE (Home, farm, factory, street, office bldg., etc.)	(CITY OR	rown) (Co	OUNTY) (STATE)
TIME (Month)	(Day) (Year) (Hour)	INJURY OCCURRED While at Not While	HOW DID INJURY OC	CUR?	
INJURY	m.	Work At work	<u></u>		
22. I hereby certi	ify that I attended the	e deceased from 9 - 2	19.5 to 9- >	, 1955 , that 1	I last saw the deceased
alive on	-2 - 19 J.J. an	d that death occurred at	2 Pm. from the	causes and on the	date stated above
SIGNATURE	111/	(Degree or title)	ADDRESS		DATE SIGNED
	J. N Ze	ga MA	luun 8	usque n	10 9-3-11
23. BURIAL, CREM REMOVAL (Spec DUT 18	ATION   DATE THERE	/ /		LOCATION (City, town,	
				Uniontown, Ma	aryland
DATE REC'D BY	LOCAL REGISTRAR'S	SIGNATURE	24. FUNERAL DIRECTO		ADDRESS
REG. 01 124 /	(A )	1 1 1 9 1	CO Promo Com	Tonorton	Manueland
117/	) I lavar	ul / malas	C.O.Fuss & Son	, raney town,	Maryland

BUREAU V. S.

SEE L JES

DECENSED

PLEASE WRITE PLAINLY, WITH

#### 08544 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8523 CERTIFICAT	E OF DEATH Reg. Dist.	No.
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	18
01	2. OSCALLATION (HOME) OF ESCALLATION	1 10
COUNTY Carroll MARYLAND	STATE / COUN	Jan St. Market Market St. Comment of the Comment of
CITY (If outside corporate limits, write RURAL LENGTH OF STATE on this place)	Y CITY (If outside corporate limits, write RURAL ar	nd give nearest town
TOWN Westminster 1 mo.	TOWN ///estminitur	27
HOSPITAL OR	STREET / (If rural give location)	/
STREET ADDRESS 8 6. Main	ADDRESS Webster Strut	,
NAME OF DECEASED: (First) (Middle)	FOWLER 4. DATE (Month) (Day Post 27	(Year) 19 \$ 5
CType or Print) (ECEL/A COSEPHINE S. SEX:   S. COLOR OR   7, SINGLE, MARRIED,   §. DATE		
RACE: WIDOWED, DIVORCED, Mark		Hours   Min.
Oa. USUAL OCCUPATIONGive kind of work done during most of working life, INDUSTRY:		COUNTRY!
Jeven if retired):		1S. A
3. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
andrew Fourler	10 atherene & over	
Yes, no, or unk.) (If Yes, give war or dates of	7. INFORMANT & ADDRESS: 99 Em	rain ,
Ino service) none	no Joseph Manger Ir. Westmin	Ten, mol.
18. MEDICAL CERTIFICAT	TION 0	Interval Between
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Onset And Dear
442X	162 6. Van Key Oxlinerso	Several
Immediate cause  (a)  DUE TO		910
Antecedent causes (s) Diseasee or conditions, if any, giving rise to the above cause stating the underlying cause last.  DUE TO	e Sollroses Genl	Syrs
(c)		
1. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
9a. DATE OF OPERATION: 1 19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY
		Yes No
1. ACCIDENT (Specify) SUICIDE OF office bldg., etc.) HOMICIDE	et, (CITY OR TOWN) (COUNTY) (S	STATE)
TIME (Month) (Day) (Year) (Hour)   INJURY OCCURED	HOW DID INJURY OCCUR?	
OF While at Not While INJURY m. Work At Work		
22. I hereby certify that I attended the deceased from	7,1953, to Sept 281955, that I last	saw the decease
alive on 28, 19 and that death occurred at	, from the causes and on the date	stated above.
Willem Treicher 1	Jestuinston mit de	24 29-1955
REMOVAL (Specify)	ERY OR CREMATORY LOCATION (City, town, or sp	unty) (State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR	24. FUNERAL DIRECTOR	ADDRESS
9-28-17 Hamit Miller 1	Mi Tankas 1 Poly 11) estmins	er. mos.

BUREAU V. E.

SEP 30 1955

SECENTEL

2411 N. Charies Street, Baltimore

8541

# CERTIFICATE OF DEATH

I. PLACE OF DEATH.	( 2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	STATE COUN	
Carroll MARYLAND CITY (If outside corporate limits, write RURAL and   LENGTH OF STAY	STATE Maryland COUNCITY (If outside corporate limits, write RURAL and	Carroll
OR give nearest town) (in this place)	OR	give newlest rown)
Town Taneytown 19 years	TOWN Taneytown STREET (If rural, give location)	7
INSTITUTION OR	ADDRESS	/
Of STREET ADDRESS	3 Frederick Street	
3. NAME OF (First) (Middle) DECEASED (Type or Print) Sarah E.	(Last) 4. DATE (Month) OF DEATH September	(Day) (Year)
F COLOR OR DACE LA SINGLE MARRIED	8. DATE OF BIRTH 9. AGE last hirthday If und Month	er i year  II under 24 hr
Female White WIDOWED, DIVORCED, (Specify) Widow	Nov. 27.1880 74 yrs. Month	Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work 10b. Kind of Business or done during most of working life, even if retired) INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housework own home	Maryland	U.S.A.
13. FATHER'S NAME		
Emanuel Fink	Catherine Snyder	
15. WAS DECRASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY ND.	17. INFORMANT AND ADDRESS	
(Yes, no, or unknown) (If yes, give war or dates of service)	Mr. Carel Frock, Taneytown, Man	ryland
18. MEDICAL CE	RTIFICATION	INTERVAL BETWEEN
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
	Λ	- O.
204, Immediate cause (a) Cerebral Her	mothage	2 aays
		0
Diseases or conditions, if any, (b)	logenous Sentenia	2 years
giving rise to the above cause stating the underlying cause last		0
(c)		1
II. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.	d anterio selenares	10 years.
19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
		Yes D No Z
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,	(CITY OR TOWN) (COUNT	
SUICIDE OF office bldg., etc.) HOMICIDE INJURY		
TIME (Month) (Day) (Year) (Hour)   INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF INJURY  m. While at Not While Work  At work		
22. I hereby certify that I attended the deceased from Movel 9	19.54, to San 2.3, 19.55, that I last	saw the deceased
alive on Sant 23, 19.55, and that death occurred at	Appress.	stated above.
alive on Sant 23, 19.55, and that death occurred at (Degree or title)	ADDRESS	stated above. DATE SIGNED
alive on Sant 23, 19.55, and that death occurred at		
alive on Sant 23, 19.55, and that death occurred at (Degree or title)  23. BURIAL CREMATION   DATE THEREOF   NAME OF CEMETE	oney lown, ma.	9-24-55
alive on Sapt 23, 19.55, and that death occurred at (Degree or title)  SIGNATURE  LONG (Degree or title)  NAME OF CEMETE	TRY OR CHEMATORY   LOCATION (City, town, or co	9-24-55 unty) (State)
alive on Sapt. 23, 19.55, and that death occurred at (Degree or title)  SIGNATURE  23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETE REMOVE LISTER Sept. 26, 1955 Reformed Company (Sept. 26, 1955)	CRY OR CHEMATORY   LOCATION (City, town, or co	9-24-55 unty) (State)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

The correct age

VS. A15

BUREAU V. S.

**SEP** 28 1955

BECEINE

8-51

VS. A15

# 8542

### CERTIFICATE OF DEATH

RE, 18 08546 Reg. Dist. No. 75 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	1
COUNTY MARYLAND . MARYLAND	STATE COUNTY	oll
CITY (If outside corporate limits, write RURAL   LENGTH OF STAY	CITY (If outside corporate limits, write RURAL and	d give pervet town)
OR and give nearest town) (in this place)	OR .	u give nearest town)
HOSPITAL OR	TOWN Mancheste	7
INSTITUTION OR ()	STREET (If rural, give location)	2 1 11
STREET ADDRESS COUNT are Gentled	ADDRESS Jash are hit	Ended
3. NAME OF (First) (Middle)	(Last) 4. DATE (Month) (Day	(Year)
(Type or Print) William It, Helpan	dt du DEATH: 9-3	- 1953
5. SEX:   6. COLOR OR   7. SINGLE, MARRIED,   8. DATE	OF BIRTH:   9. AGE inst birthday:   IF UNDER 1	YEAR   IF UNDER 24 HRS.
RACE: WIDOWED, DIVORCED, (Specify)	1-71   7   Months   1	Days Hours   Min.
red 10/2	// (0 / / ) yrs,	
10a. USUAL OCCUPATION (Give kind of 10b. KIND OF BUSINESS OF work done during most of working life, 1NDUSTRY:	BIRTHPLACE (State or foreign country);	2. CITIZEN OF WHAT COUNTRY?
even if retired):	Parolina Bach	1/5-A
IS. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	0 0 / 1
- Linda . h H 18 1	60. A. 14. B	
I/Walry Vernands	mayella jourse	allsi.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: 17. (Yes, no, or unk.); (If Yes, give war or dates of	INFORMANT & ADDRESS:	chister
service)	1 1 1 1 1 1 I	ce ar gr
	Music F. R. Wigaras	ma:
	ERTIFICATION	INTERVAL BETWEEN
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	4	ONSET AND DEATH
100x	arcenoma	1un
Immediate cause (a)		
Antecedent cause(s)	00.	6
Diseases or conditions, if any, (b)	ceros	3 9/20
giving rise to the above cause DUE TO	0 1	
stating underlying cause last (c) Pulmmu	en Emmherson	15000
II. OTHER SIGNIFICANT CONDITIONS:	7	13.00
Conditions contributing to the death but not related to the disease or condition causing death.	U	
19a. DATE OF OPERATION:   19b. MAJOR FINDINGS OF OPERATION:		1 20. AUTOPSY?
		Yes No
21. ACCIDENT (Specify) PLACE (Home, farm, factory, street,	(CITY OR TOWN) (COUNTY)	(STATE)
SUICIDE OF office bldg., etc.) INJURY	(000011)	(22127)
TIME (Month) (Dny) (Year) (Hour)   INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF While at Not while	HOW DID INSULT OCCUR:	
INJURY M. work ☐ at work ☐		
22. I hereby certify that I attended the deceased from aug.	1975 to lent 3 1955 that I last s	aw the deceased
alive on sent. 195.5., and that death occurred at		
SIGNATURE (DEGREE OR TITLE		DATE SIGNED
WI I Fround M.D	Mars has to said	9/1/5
	Manual Ma	1/6/33
23. BURIAL, CREMATION DATE THEREOF NAME OF CEMETER REMOVAL (Specify):	Y OR CREMATORY LOCATION (City, town, or ed	ounty) (State)
Bured 9/1/03 reformed	em manchester	Ruellot my
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDRESS
Desc 6/55 Mrs. Not Denner	+ reasych Ducker Ha	noveral_

BUREAU Y. S.

SEP 16 1955

DECENA ED

情

MARGIN RESERVED FOR BINDING

- 10 - 53

VS. A15.

### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 08547

CERTIFICATI	E OF DEATH Reg. Dist	. No. / /
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASE	D:
COUNTY PRIVALL MARYLAND	STATE MA COUNTY PA	unall.
CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and give pearest town) (in this place)	CITY(If outside corporate limits, write RURAL a	and give nearest town)
X TOWN Johnsvelle 54 years	TOWN Johnsville	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS	ADDRESS (If rural give location)	0.
3. NAME OF First (Middle)	(Last) 4. DATE (Month)	Day) (Year)
(Type or Print) Sillie Frence Ho	snell OF DEATH Cleft.	30 1955
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED, (Specify): 3-	of the boundary of the boundary	Days Hours   Min.
IOA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	11. BIRTHPLACE (State or foreign country): 12.	CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
(Yes, no, or unk.) (If Yes, give war or dates of service)	Robert Gornell. Lyka	ille me.
18. MEDICAL CERTIFICAT	TION	INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
443 Apper kusin	a cordio vasculor observe	senslysen
ANTECEDENT CAUSE (S)		0
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST,  DUE TO	oscerno e ces. myo estado	searly son
(c) Jende	chauser	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE	+:	- 11-
DISEASE OR CONDITION CAUSING DEATH.	111m	2.4 mm
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	N	20. AUTOPSY?
21A. ACCIDENT WAS UNDERLYING   CONTRIBUTING   CAUSE OF DEATH OF INJURY street, office bldg.,	tory, 21c. WHERE DID (City or town) (Coun INJURY OCCUR?	ty) (State)
21b. TIME (Month) (Day) (Year) (Hour)   21E INJURY OCCURRED While Not while	21F. HOW DID INJURY OCCUR?	
OF INJURY  M. while Not while at work at work		
22. I hereby certify that I attended the deceased from 143.	5, 19, to 30 5 40, 1955, that I last	saw the deceased
alive on 29 Sept., 1955 and that death occurred at SIGNATURE	\$2.45M, from the causes and on the date	
	1.D. Sypsalle, Md. 3	2 2407-1933
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET REMOVAL (SPECIFY)	ERY OR CREMITTORY LOCATION (City, town, or	county) (State)
DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE	24 FUNERAL DIRECTOR	ADDREGS

BUREAU V. S. GGET G 100 CONTRACTOR OF THE STATE OF THE ST

### MARYLAND STATE DEPARTMENT OF HEALTH

08548

## CERTIFICATE OF DEATH

Item 18 Film G186 9-16-55 ams

FOR MEDICAL EXAMINERS

Reg. Dist. No. 26

TOM MIDDIC	Reg. Dist. No	J
I. PLACE OF DEATH- COUNTY	2. USUAL RESIDENCE (HOME) OF DECEASED-	x. 11
MARYLAND	Markann low	200
OR give nearest town / (in this place)		ve nearest town)
X TOWN Trusal Wishminster 20 yr	2' TOWN may Wishminste	n X
HOSPITAL OR INSTITUTION OR ()	STREET (If rural, give location)	/
NAME OF		
3. NAME OF (First) (Middle) DECEASED (Type or Print) EMMA	(Last)  AINES  4. DATE (Month)  OF  DEATH, SAT:	(Day) (Year)
5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCE	8. DATE OF BIRTH 9. AGE last birthday If under Months	The state of the s
10a. USUAL OCCUPATION (Give kind of work 10b. Kind of Business	or   11. BIRTHPLACE (State or foreign country)   12	2. CITIZEN OF WHAT
done during most of working life, even if retired) INDUSTRY		COUNTRY?
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
Vaul torike	Jaroh Stimmer	
15. WAS DECKASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO	17. INFORMANT AND ADDRESS	4 .
(Yes, no, or unknown) (If yes, give war of dates of 2/2/-/6-/) 3	O Viola Brown westmi	motion mod
	L CERTIFICATION	1
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN
1 80 7 7 1 1		ONSET AND DEATH
Immediate cause (a) Mudeterne	ined	
giving rise to the above cause	sion y Card as T8	month,
stating the underlying cause last		
H. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not		
related to the disease or condition causing death.  19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATIO	N	20. AUTOPSYT
A CONTRACTOR OF CONTRACTOR		
21. EXTERNAL CAUSE WAS   PLACE (Home, farm, factory, str	reet, (CITY OR TOWN) (COUNTY)	Yes No V
PRIMARY OR CONTRIBUTING OF Office bldg., etc.) CAUSE OF DEATH.		(0.11.2)
TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED OF While at Not white	HOW DID INJURY OCCUR?	
INJURY m. work at work		
22. I certify that I took charge of the remains described above, held obtained by said Autopsy, Inspection or Inquiry, find that said	deceased died on the dry stated above, and death in my	from the evidence opinion resulted
from: natural causes , accident , suicide , homicide SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
(Degree of title)	1	IT /2
Jacules J. March Deputy Mede	intexamine Wilmester The	9/3/5
REMOVAL (Specify)	ETERY OR CREMATORY LOCATION (City, town, or count	ty) (State)
DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
REG.	1 / 2 / 4 // t -	75 /h 1
9-4-3) Hamut Mully	YIJanijan Rongissmin	sur inn.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15A

3 1. 23

BUREAU V. S.

5361 4 das

DECEINED AND SHE

# 8545 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08549

CERTIFI	CATE	OF	DEATH

Reg. Dist. No.

ly.	1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED	D:
gib	COUNTY Carroll MARYLAND	STATE Maryland COUNTY	
le	CITY (If outside corporate limits, write RURAL) LENGTH OF STAY	CITY(If outside corporate limits, write RURAL a	nd give nearest town)
nd	✓ OR and give nearest town) (in this place)	OR	- 1
od .	Normal Sykesville (Rural) since 6/8/07	Dailumore City	3101.4
of death clearly and legibly	STREET ADDRESS Springfield State Hospital	STREET (If rural give location) ADDRESS 2526 BoarmanAvenue	
C			Day) (Year)
atl	DECEASED: (Type or Print) Joseph — HA	NAN OF DEATH: September	r 22 1955
de	5. SEX:   6. COLOR OR   7. SINGLE, MARRIED,   8. DATE	OF BIRTH: 9. AGE last birthday IF UNDER 1 Y	
	male white WIDOWED, DIVORCED. (Specify) single 1879	Months D	ays Hours Min.
causes	IOA. USUAL OCCUPATION (Give kind of 108. KIND OF BUSINESS	11. BIRTHPLACE (State or foreign country):  12.	CITIZEN OF WHAT
ans	work done during most of working life, OR INDUSTRY:		COUNTRY?
	110116	Baltimore, Maryland Uni	ted States
the	13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
te	James H. Hanan	Dellia Frost	
write	18. WAR DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
0)	(Yes, no, or unk.) (If Yes, give war or dates of service)	Records of Springfield State H	osnital
62	18. MEDICAL CERTIFICATI		
please	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
13	491×		ALCOHOLD BY
ns	/ MMEDIATE CAUSE (A) Aspiration	pneumonia	5 days
cia	ANTECEDENT CAUSE (S:		
Physicians	DISEASES OR CONDITIONS, IF ANY, (B)		
Ph	GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST.		
	(C)		
an	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING		
ort	TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Cataton	ic schizophrenia	50 years
important.	19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
1			YES NO
113	21A. ACCIDENT WAS UNDERLYING   21B. PLACE (Home, farm, factor	OTH 210 MULTIPE DID (City on Asser) (Compa	
especially	OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	etc. INJURY OCCUR?	y) (State)
713	21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work	21F. HOW DID INJURY OCCUR?	
is		7 48 6 1 60 -77	
age	22. I hereby certify that I attended the deceased from Sept.	. L 1947, to Sept. 22 1955, that I last	saw the deceased
	alive on Sept. 22., 1955, and that death occurred at	12:31M, from the causes and on the date s	stated above.
correct	1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		/22/55
00	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE	RY OR CREMATORY LOCATION (City, town, or	county) (State)
	DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
	REGISTRAR 12 10:5-	Benord atik ble	Mus 2mg

BUREAU V. E.

THE REPORT OF THE PROPERTY AND THE PROPERTY OF 
AND AND THE PERSON OF A PRINCIPAL SECTION OF THE PERSON OF

SEP 28 1955

BECEINE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1855)

			111
Reg.	Dist.	No.	74

1		8545 CE	RTIFICATE	OF DEATH Reg.	Dist. No.
2	ull.	1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECE	ASED:
7	ion carefully and legibly.	COUNTY CARROLL  CITY (If outside corporate limits, write RURAL OR and give nearest town)  Town Rural - Sykesville, Md.	LENGTH OF STAY	STATE Maryland COUNTY I CITY(If outside corporate limits, write RUR OR TOWN Baltimore	Baltimore City AL and give nearest tow
M	information clearly and	HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield Sta	te Hospital	ADDRESS 1809 Ashburton St.	itlon)
	of	DECEASED: (Type or Print) ALMA	EMMA H	ASLUP 4. DATE (Month) OF DEATH: 9	(Dhy) (Year) 25 1955
4	y item s of de	Female   COLOR OR 7. SINGLE, MAR WIDOWED, D (Specify) Div	orced 11/	of BIRTH: 9. AGE last birthday 15 uno 15/04 50 yrs. Month	The state of the s
NG	causes	work done during most of working life. even if retired): Domestic	ND OF BUSINESS	II. BIRTHPLACE (State or foreign country):  Maryland	COUNTRY?
BINDING	Supply te the	13. FATHER'S NAME: Henry W. Wolfe		14. MOTHER'S MAIDEN NAME: Emily Zimmerman	
FOR 1	IK.	(Yes, no, or unk.) (If Yes, give war or dates of service)	SOCIAL SECURITY ND.	17. INFORMANT & ADDRESS:	)
	ING	I DISEASES OR CONDITIONS DIRECTLY LEAD	IEDICAL CERTIFICATION	ON	INTERVAL BETWEE
RESERVED	UNFAD sicians:	ANTECEDENT CAUSE (8)		e Lung (right)	months
IN RE	rH Un	DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	то		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING Schizophrenic reaction, paranoid DISEASE OR CONDITION CAUSING DEATH.

198. MAJOR FINDINGS OF OPERATION

218. PLACE (Home, farm, factory, 21c. WHERE DID (City or town) 21F. HOW DID INJURY OCCUR?

20. AUTOPSYT (County) (State)

Years

OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. (IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21A. ACCIDENT WAS UNDERLYING

21E INJURY OCCURRED Not while While at work at work

22. I hereby certify that I attended the deceased from 8/31 , 1955, to 9/25 ...., 1955, that I last saw the deceased

and that-death occurred at 9:15 PM, from the causes and on the date stated above. DATE SIGNED Sykesville, Maryland

(State)

WRITE

OR

TYPI correct

SE

age 国

TOTAL DESCRIPTION OF STREET

BUREAU V. S.

THE THE LANGUAGE CONTRACT OF THE STATE OF TH

SECEINED

TOWN

3. NAME OF

DECEASED:

HOSPITAL OR

(Type or Print)

INSTITUTION OR

STREET ADDRESS

carefully

information

of

item

Supply the

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DING

eas

sicians:

Phys

portant.

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of

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (18551

CERTIFICATE OF DEATH

F D	EATH	R	eg. Dis	st. I	Vo.	74	۲
USUAL	RESIDENCE (H	OME) OF D	ECEAS	ED:			
STATE	Maryland	COUNTY	Gar	ret	t		
	outside corporate					nearest	town)

2. USUAL RESIDENCE (HOME STATE Marvland TOWN

(in this, place,) since 3/

MARYLAND

Springfield State Hospital

(Middle)

(Last)

HERSHBERGER

STREET

ADDRESS

4. DATE (Month) (Day) (Year) DEATH: Sept.

Months

(If rural give location)

9. AGE last birthday IF UNGER I YEAR

6. COLOR OR | 7. SINGLE, MARRIED, 8. DATE OF BIRTH: white WIDOWED, DIVORCED (Specify) married male unknown 10A. USUAL OCCUPATION (Give kind of work done during most of working life, 10B. KIND OF BUSINESS

Rural - Sykesville

(First)

Harry

OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): West Virginia

112. CITIZEN OF WHAT COUNTRY? United States

IF UNDER 24 HRE

INTERVAL BETWEEN

ONSET AND DEATH

Hours |

unknown - retired

13. FATHER'S NAME:

John S. Hershberger IS. WAS DECEASED EVER IN U.S. ARMED FORCEST

1898-1899

10200 L. 104809194 (Yes, no, or unk.) (If Yes, give war or dates yes of service) Spanish-American

18. MEDICAL CERTIFICATION

unknown 17. INFORMANT & ADDRESS:

14. MOTHER'S MAIDEN NAME:

Records of Springfield State Hospital

Rural - Kitzmiller

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE

Bronchopneumonia (A) DUE TO

4 days

ANTECEDENT CAUSE (8)

Arteriosclerosis (B) DUE TO

than 9 yrs. more

DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST.

(C) ---

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Senile brain disease 198. MAJOR FINDINGS OF OPERATION

more than 3

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH

19A. DATE OF OPERATION:

21B. PLACE (Home, farm, factory. OF INJURY street, office bldg., etc.

21c. WHERE DID (City or town) INJURY OCCUR?

NO DO (County) (State)

(IF EITHER, NOTIFY MEDICAL EXAMINER) 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E INJURY OCCURRED While Not while at work at\_work

21F. HOW DID INJURY OCCUR?

M. D.

NAME OF CEMETERY OR CREMATORY

22. I hereby certify that I attended the deceased from July 3 , 1953, to Sept. 6, 1955, that I last saw the deceased alive on Sept. 6 19 55, and that death occurred at 1:25AM, from the causes and on the date stated above. correct SIGNATURE DATE SIGNED my, M. D. Martin Gross, Sykesville, Maryland

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

24. FUNERAL DIRECTOR

LOCATION (City, town, or county)

DATE REC'D BY LOCAL

DATE THEREOF

A15 ri

THE REPORT OF THE PROPERTY OF

EUREAU V. S. SEP II 1985

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08552

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1					/
>	1. PLACE OF DEATH:		2. USUAL RESIDEN	CE (HOME) OF DECE	ASED:
legibly	COUNTY CARROL MARYLA	ND	STATE md	COUNTY	D .
	CITY (If outside corporate limits, write RURAL) LENGT	H OF STAY	CITYIIf outside con		AL and give nearest town)
Du n	TOWN SURESVILLE IVECTOR	this place)	TOWN Pa	etimore (	Tity 3101.4
clearly and	HOSPITAL OR Springfield State	Hosp.	STREET ADDRESS & DE	OC Bellon	
death c	3. NAME OF (First) (Middle) DECEASED: (Type or Print) ANNA	He	Last) 2-5.5 (Hessa	4. DATE (Month) OF DEATH:	(Day) (Year) 24-1955
No.	5. SEX:   6. COLOR OR   7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WILCW		7-89	Te yrs. 2	
causes	OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (Sta	ate or foreign country):	12. CITIZEN OF WHAT
he	13. FATHER'S NAME:		14. MOTHER'S MAIL	1 50	
e c	Frank Myers		Mara	aret Mi	yers
e write the	(Xes, po) or unk.) If Yes, give war or dates of service)	URITY ND.	Mrs Anthony	Atman-24	-13 Pelham Are
ease	18. MEDICAL		ION		INTERVAL BETWEEN
ā,	I DISEASES OR CONDITIONS DIRECTLY LEADING TO D		,,	- 1	ONSET AND DEATH
2	30/ X IMMEDIATE CAUSE (A) Cere	bral A	lemorrhage elerosis	see h Az	- 2 days
ciar	ANTECEDENT CAUSE (8:	erios	clerosis		
rnysicians	DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  (B)  DUE TO				
	(C)				
important.	II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	185 m	sociated with	arteriorda	proce
E I	19a. DATE OF OPERATION: 198. MAJOR FINDINGS OF	OPERATION			20. AUTOPSY7
					YES NO P
especially	21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Homor Contributing Cause of Death OF INJURY street (IF EITHER, NOTIFY MEDICAL EXAMINER)	t, office bldg.,	etc. INJURY OCCUR?		County) (State)
is est		OCCURRED Not while	21F. HOW DID IN.	JURY OCCUR?	
0)	22. I hereby certify that I attended the deceased fr	om 3 - 3	-, 1957, to 7-	- 24, 195-5, that I	last saw the deceased
ect ag	alive on 9-24, 19-55, and that death of	Pell	ADDRESS	causes and on the de	DATE SIGNED
correct	23. BURIAL, CREMATION, DATE THEREOF NAME		D. Sylleaus K	LOCATION (City, tow	9 - 2 4 - 5 1 n, or county)     State)
	Busial 9-27-55	Holy x	Cudinier	Ballin	ne, md.
	DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIR	ECTOR TO THE CONTRACT OF THE C	ADDRESS OF

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

S. A15 - 10 -

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### MARVIAND STATE DEPARTMENT OF HEALTH\_RALTIMORE 18

MARTDANI	DIALE	DEL ARTHUR	I OI	HEALITH.	-DALL	IMORE,	10
MEDICAT	TAY A ME	TATEDO S	CITAL	DISTING	A FIRTH A	OR	TATAL

MEDICAL EXAMINER S CERT	IIIICAIL OF DEATH	No
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Carroll MARYLAND	STATE Maryland COUNTY City	
CITY (If outside corporate limits, write RURAL OR and give nearest town)  TOWN Sykesville LENGTH OF STAY (in this place)  1y. 6m. 20d.	CITY (If outside corporate limits write RURAL and OR TOWN Baltimore City (15)	give nearest town)
IIOSPITAL ÖR INSTITUTION OR	STREET (If rural, give location)	1
STREET ADDRESS Springfield State Hospital	3053 Spaulding Avenue	1
3. NAME OF (First) (Middle) DECEASED:	(Last) 4. DATE (Month) (Day)	(Year)
(Type or Print) ALFRED DAVIDSON J(	ONES DEATH September 1	19 55
RACE: WIDOWED DIVORCED.	OF BIRTH: 9. AGE last birthday: IF UNDER 1 Y. Months Da	
Male White (Specify): Single 10-	26-90   64 yrs.   26   11. BIRTHPLACE (State or foreign country):   12.	CYTHATIN OR WILLIAM
work done during most of work life, even if retired): Grocery Clerk		COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	0.00
Manager Homes Toron	Name Eller NaCulland	
William Henry Jones  15. Was Decease Ever In U.S. Armed Forces 7 16. Social Security No.:	Mary Ellen McCullough 17. INFORMANT & ADDRESS:	
(1es, no, or unk.) (If les, give war or dates of		
No service)	Hospital records	
	AL CERTIFICATION	INTERVAL BETWEEN
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		ONSET AND DEATH
Immediate cause (a) Bronchopne umonia	a	2-3 days
DUE TO		
Antecedent cause(s)		
Diseases or conditions, If any, (b)giving rise to the above cause DUE TO		
stating underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING		
TO THE DEATH BUT NOT RELATED TO THE Schizophre	enic reaction, catatonic type.	1½ yrs.+
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?
21a. EXTERNAL CAUSE WAS   21b. PLACE (Home, farm, factory,	21c. (City or town) (County)	(State)
PRIMARY Or CONTRIBUTING OF street, office bldg., etc.,	00	Maryland
21d. TIME (Month) (Day) (Year) (Hours) 21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?	nar yranu
OF INJURY 8 5 55 11.5M. While at work m	Pt. fell out of bed.	
22. I hereby certify that I took charge of the remains describ		
find that death resulted from: Natural causes [], Accid		mined cause
SIGNATURE 1	CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER	DATE SIGNED
James J. Morch	M. D. ASSISTANT MEDICAL EXAM.	9/13/50-
REMOVAL (Specify):	Y OR CREMATORY LOCATION (City, town, or co	(
Burial 9/17/55 Mt. Olive	Randallstown, N	ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. VS. A15A - 5 - 53

MARGIN RESERVED FOR BINDING

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I. PLACE OF DEATI	H:		2. USUAL RESI	DENCE (HOME) C		H No. 74
COUNTY Carr	7017	MARYLAND	STATE Ma	rwland COU	NTY	
CITY (If outside comes of the c	orporate limits, write	RURAL LENGTH OF (in this plant)	STAY CITY (If our	tside corporate limit	ts write RURAL	and give nearest town)
HOSPITAL OR STREET ADDRESS	Springfield	d State Hospital	STREET ADDRESS 10	(If ) 18 East Hof	rural, give locat	et?
3. NAME OF DECEASED: (Type or Print)	(First) Anna	(Middle) Mary	(Last) KAY	4. DATE OF DEATH	(Month)	(Day) (Year) 29 19 55
	RACE: V	VIDOWED, DIVORCED, Specify): Single	6/13/84	9. AGE last bi	rthday: IF UNDI Months	ER I YEAR IF UNDER 24 HRS.  B Days Hours Min.
10a. USUAL OCCUP. work done during even if retired):	or most of monk lit	of 10b. KIND OF BUSIN	Mary	land	reign country):	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME				MAIDEN NAME:		
Richar	d L. Kay	01		ly Norris		
(Yes, no, or unk.) (If	ver In U.S. Armed For Yes, give war or date vice)	RCES ? 16. SOCIAL SECURITY Sof	Record, Spr		ate Hospi	.tal
331X	NDITIONS DIRECTL	Y LEADING TO DEATH:		ON		INTERVAL BETWEEN ONSET AND DEATH
Immediate ca	use (a).		iia			5 days
Antecedent ca Diseases or condi	USe(s) tions, if any, (b) e above cause DUE T	ro Cerebral hemor	rhage, right,	lenticulo-s	triate ar	
Antecedent ca Diseases or condigiving rise to the stating underlying the condition of the c	DUE 7 USe(s) itions, if any, (b) te above cause DUE 7 ng cause last (c) CANT CONDITIONS	Cerebral hemor	rhage, right,			
Antecedent ca Diseases or condi giving rise to the atating underlyir II. OTHER SIGNIFIC TO THE DEAT	DUE 7 USe(S) tions, if any, (b) e above cause DUE 7 ng cause last (c) AANT CONDITIONS H BUT NOT REL	Cerebral hemor	rhage, right,	ome associa	ted	tery 20 days
Antecedent ca Diseases or condi giving rise to th atating underlyir TO THE SIGNIFIC TO THE DEATE DISEASE OR CO 19a. DATE OF OPER	UISE(S)  tions, if any, (b) tons, if any, (b) te above cause DUE Tons ag cause last (c) ATT CONDITIONS ABOUT NOT RELA NOITION CAUSING RATION: 19b. MAJ	Cerebral hemor	rhage, right,	ome associa	ted	tery 20 days
Antecedent ca Diseases or condi giving rise to th Lating underlyir TO THE SIGNIFIC TO THE DEATH DISEASE OR CO 19a. DATE OF OPEL  21a. EXTERNAL CAL PRIMARY  OF CO CAUSE OF DEATH	USE (S) tions, if any, (b) tions, if any, (b) te above cause DUE 7 ag cause last (c) AT CONDITIONS H BUT NOT RELA NDITION CAUSING RATION: 19b, MAJ USE WAS NTRIBUTING []	Cerebral hemore Contributing Chrore ATED TO THE Chrore DEATH. With CER OR FINDING OF OPERAT  CIb. PLACE (Home, farm, OF street, office bl INJURY hOSPILA)	rhage, right, ric brain syndrebral arterios	ome associa clerosis town)	ted (County) Carroll	tery 20 days  12 years 20. AUTOPSY?
Antecedent ca Diseases or condi giving rise to the stating underlyir  II. OTHER SIGNIFIC TO THE DEATH DISEASE OR CO 19a. DATE OF OPEN  21a. EXTERNAL CAI PRIMARY Or CO CAUSE OF DEATH 21d. TIME (Month) OF INJURY	USE (S)  USE(S)  USE(S)  USE (Bany, (b)  Each and any, (b)  USE (C)	Cerebral hemore Contributing Chrore To THE DEATH. With CER OR FINDING OF OPERAT  21b. PLACE (Home, farm, OF street, office ble INJURY hOSPITAL  IT) 21e. INJURY OCCURE ON While at Note	rhage, right,  ric brain syndr  bral arterios  factory,  factory,  factory,  gran, etc.,  Patient	ome associa clerosis  town) lle ID INJURY OCCU fell from	ted (County) Carroll R? Shair str	12 years 20. AUTOPSY? Yes No (State) Maryland
Antecedent ca Diseases or condi giving rise to the atting underlyir  II. OTHER SIGNIFIC TO THE DEATH DISEASE OR CO 19a. DATE OF OPEN  21a. EXTERNAL CAI PRIMARY Or CO CAUSE OF DEATH 21d. TIME (Month) OF INJURY  22. I hereby cert	USE (S)  USE(S)  USE(S)  USE (ANT CONDITIONS  H BUT NOT RELA  NOTION CAUSING  RATION: 195. MAJ  USE WAS  NTRIBUTING   (Day) (Year) (Hou  9 55 6:30  ify that I took che resulted from:	CONTRIBUTING Chror TO  CONTRIBUTING Chror TED TO THE DEATH. With Cer OR FINDING OF OPERAT  21b. PLACE (Home, farm, OF street, office bl INJURY HOSPITAL  ATT) 21c. INJURY OCCURE OTHER While at Noty	rhage, right,  ric brain syndr bral arterios  factory, ls., etc.,  AED  vhile vhile vhile vhile described above, held Accident [], Suich	town)  lle ID INJURY OCCU  fell from I an Autopsy	(County) Carroll R? Shair str ], Inspection de [ ], Und	12 years 20. AUTOPSY? Yeak No (State) Maryland Tiking left chir
Antecedent ca Diseases or condigiving rise to the atting underlyir  II. OTHER SIGNIFIC TO THE DEATH DISEASE OR CO  19a. DATE OF OPEI  21a. EXTERNAL CAI PRIMARY Or CO CAUSE OF DEATH 21d. TIME (Month) OF INJURY 9  22. I hereby cert find that deat SIGNATURE	USE (S)  tions, if any, (b) e above cause DUE To the Color of the C	Cerebral hemore Contributing Chrorated To THE DEATH. With cereor OR FINDING OF OPERATOR Street, office black in Jury Occuration of the Injury Occu	rhage, right,  ric brain syndr bral arterios  factory, gr., etc.,  Patient described above, held Accident , Suich CR M. D. As	town)  lle  in injury occu  fell from  an Autopsy  de  , Homici  Hief Medical EPUTY MEDICAL  ESISTANT MEDICAL  SSISTANT MEDICAL  RY LOCATION	(County) Carroll R? Shair str ], Inspection de [ ], Und	12 years   20. AUTOPSY?   Yest No   (State)   Maryland   Tiking left chi:   Inquiry   , and letermined cause   DATE SIGNED   9/26/55

PLEASE

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VS. A15A - 5 - 53

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Supply every item of information carefully.

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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8551	CERTIFICATE	() H.	DEA	T

RE,	18	08554
Reg.	Dist.	08554 No.

	- OZ DISL	110.
1. PLACE OF DEATH:	2. USUAL RESIDENCE (HOME) OF DECEASED	D:
COUNTY CATTOLL MARYLAND	STATE MANYJANA COUNTY	
CITY (If outside corporate limits, write RURAL COR and give nearest town) (in this place)  TOWN  CITY (If outside corporate limits, write RURAL (in this place))  (in this place)	CITYII outside corporate limits, write RURAL a OR TOWN Baltimore	nd give nearest town)
HOSPITAL OR STORMSfield State 15 STREET ADDRESS HOSPITAL	STREET ADDRESS 3329 Electra Ave 1	Belto 13 4d.
3. NAME OF (First) (Middle) DECEASED: (Type or Print) Frances R. Klau	(Last) 4. DATE (Month) (I	(Year) 15 19 55
5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DATE WIDOWED, DIVORCED, WIDOWED, Wydowdd 1-1	OF BIRTH: 9. AGE last birthday   PUNDER 1 Y   Months   D	EAR   IF UNDER 24 HRS.
work done during most of working life. even if retired):  WILD OF BUSINESS OR INDUSTRY:  None,	11. BIRTHPLACE (State or foreign country): 12.  Kawsas	CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	Hospital relords	
18. MEDICAL CERTIFICAT	rion	INTERVAL BETWEEN
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		ONSET AND DEATH
IMMEDIATE CAUSE (A) CORON	ary ocillesson	Mulles
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY,  (B)	leropi heart diseese	mkunur
STATING UNDERLYING CAUSE LAST.  (C)  GIVING RISE TO THE ABOVE CAUSE DUE TO  STATING UNDERLYING CAUSE LAST.	alized watericsclerosis	muknow
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING C. 12. S TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	of sois ated or it signile brein	2 2 minule
19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION	N /	20. AUTOPSY7
21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fac OR CONTRIBUTING 2AUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER)	ctory. 21c. WHERE DID (City or town) (Count INJURY OCCUR?	ty) (State)
21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work 1		
alive on 9-14-, 1955, and that death occurred at	30-, 19 55 to 9- 5, 19 53 that I last 121/2M, from the causes and on the date ADDRESS ADDRESS ADDRESS DATE AND PARTY OF THE SERVICE OF THE SE	
23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET REMOVAL (SPECIFY) 9-17-55 Doklar	~	county) (State)
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS

BUREAU V. S.

0999				0.0555
MARYLAND STATE D	EPARTMENT OF	HEALTH—BALT	CIMORE, 18	Reg. Dist.
MEDICAL EXAMIN	VER'S CER	RTIFICATE	OF DEATH	No. 70
. PLACE OF DEATH:		2. USUAL RESIDENCI	E (HOME) OF DECEASED:	
COUNTY Corrace &	MARYLAND		and county Carrol	1
OR and give nearest town) TOWN	(In this place)	CITY (If outside co	orporate limits write RURAL a	and give nearest town)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Rose	STREET ADDRESS	(If rural, give location	) /
NAME OF DECEASED: (Type or Print) ROSE MAT	(Middle)	(Last)	4. DATE (Month) (DOF DEATH Sept	20 19 dJ
SEX:   6. COLOR OR   7. SINGL	E, MARRIED, 8. DAT		AGE last birthday: IF UNDER Months	I YEAR   IF UNDER 24 HRS. Days   Hours   Mln.
0a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) housework	Ob. KIND OF BUSINESS ( INDUSTRY: Own home		(State or foreign country):	12. CITIZEN OF WHAT COUNTRY? U.S.A.
3. FATHER'S NAME:		14. MOTHER'S MAID	EN NAME:	
Joseph Lang		Lidwina Gutm	ann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of	16. SOCIAL SECURITY No.:	17. INFORMANT & AD		
no   service)	none	Joseph A. Klei	n,6130 Marglenn A	ve., Balto., Md
Immediate cause  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)	ADING TO DEATH:	e hemore	Lt g	INTERVAL BETWEEN ONSET AND DEATH
I OTHER SIGNIFICANT CONDITIONS CONT TO THE DEATH BUT NOT RELATED DISEASE OR CONDITION CAUSING DEA	TO THE			
9a. DATE OF OPERATION: 19b. MAJOR F				20. AUTOPSY? Yes □ No □
PRIMARY OF CONTRIBUTING OF CAUSE OF DEATH.	LACE (Home, farm, factor F street, office bldg., et NJURY	21c. (City or town)	ytown learne	(State)
OF INJURY 9 20 55 12 M.	While at Not while work at work	1 autore	obile ase	sent
22. I hereby certify that I took charge find that death resulted from: Nasignature	e of the remains descr tural causes ☐, Acc	ident , Suicide CHIEF	Autopsy  , Inspection [ , Homicide  , Under MEDICAL EXAMINER MEDICAL EXAMINER ANT MEDICAL EXAM.	termined cause .  DATE SIGNED  9/20/5'1
	955 St. Joseph	ry or crematory 's Cemetery	LOCATION (City, town, or Taneytown, Maryl	and
PATE REC'D BY LOCAL   REGISTRAR'S 8	M Mehou	C.O.Fuss & S	on, Taneytown, Ma	ADDRESS ryland

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BUREAU V. S.

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VS. A15A - 5 - 53

|   | 8553<br>MARYLAND STATE DEPARTMENT OF                                                                                                                   | HEALTH—BALTIMORE, 18                                  | 08556<br>Reg. Dist.      |
|---|--------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|--------------------------|
|   | MEDICAL EXAMINER'S CER                                                                                                                                 | TIFICATE OF DEATH                                     | No. 74                   |
|   | 1. PLACE OF DEATH:                                                                                                                                     | 2. USUAL RESIDENCE (HOME) OF DECEASED:                |                          |
|   | COUNTY Carroll MARYLAND                                                                                                                                | STATE Maryland COUNTY City                            |                          |
|   | CITY (If outside corporate limits, write RURAL   LENGTH OF STAY                                                                                        | CITY (If outside corporate limits write RURAL and     | give nearest town)       |
|   | OR and give nearest town) (in this place)  TOWN Sykesville 7mo. lidays                                                                                 | TOWN Baltimore                                        | 3 VO 1-4                 |
|   | HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital                                                                                   | STREET ADDRESS 1807 N. Broadway                       | <u> </u>                 |
|   | 3. NAME OF (First) (Middle) DECEASED:                                                                                                                  | (Last) 4. DATE (Month) (Day                           | ) (Year)                 |
|   |                                                                                                                                                        | AUSTER DEATH September                                |                          |
|   | 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, 8. DAT. WIDOWED, DIVORCED, 8. DAT.                                                                             | E OF BIRTH: 9. AGE last birthday: IF UNDER 1 Y        |                          |
|   | Female   White   (Specify): Widowed   6-                                                                                                               | 18-76 79 yrs. Months Da                               |                          |
|   | 10a. USUAL OCCUPATION (Give kind of work done during most of work life, INDUSTRY:                                                                      | OR   11. BIRTHPLACE (State or foreign country):   12. | CITIZEN OF WHAT COUNTRY? |
|   | even if retired): Dressmaker                                                                                                                           | Maryland                                              | U.S.A.                   |
|   | 13. FATHER'S NAME:                                                                                                                                     | 14. MOTHER'S MAIDEN NAME:                             |                          |
|   | George Kurz                                                                                                                                            | Margaret Wack                                         |                          |
|   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: (Yes, no, or unk.) (If Yes, give war or dates of                                  | 17. INFORMANT & ADDRESS:                              |                          |
|   | No service) — Unite -                                                                                                                                  | Hospital Records                                      |                          |
|   | 18. MEDIC                                                                                                                                              | CAL CERTIFICATION                                     | 1 -                      |
|   | I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                                                   | ral valvular disease                                  | ONSET AND DEATH          |
| 1 | Immediate cause  Antecedent cause(s)  Antecedent cause(s)                                                                                              | of the breast                                         | mouths                   |
|   | Diseases or conditions, if any, (b) giving rise to the above cause DUE TO                                                                              |                                                       |                          |
| 9 | A stating underlying cause last                                                                                                                        |                                                       |                          |
|   | II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CDC                                                                                                      | 211 21 21 21 21 21 21 21 21 21 21 21 21               | 4 2.                     |
| 1 | 11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CBS assoc TO THE DEATH BUT NOT RELATED TO THE CBS assoc DISEASE OR CONDITION CAUSING DEATH. CETEBRAL art | eriosclerosis, with psychotic rea                     | ct. Years                |
|   | 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                                                               |                                                       | 20. AUTOPSY? Yes 🖾 No 🗆  |
|   | 21a. EXTERNAL CAUSE WAS 21b. PLACE (Home, farm, factory                                                                                                | y, 21c. (City or town) (County)                       | (State)                  |
|   | PRIMARY or CONTRIBUTING OF street office blog etc INJURY HOSPITAL                                                                                      | Sykesville Carroll                                    | Maryland                 |
|   | 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while                                                                          | 21f. HOW DID INJURY OCCUR?                            |                          |
|   | INJURY 9-3-55 2: 10AM. work at work X                                                                                                                  |                                                       |                          |
| 2 | 22. I hereby certify that I took charge of the remains descri                                                                                          | ibed above, held an Autopsy [], Inspection []         | , Inquiry [], and        |
| , | find that death resulted from: Natural causes [], Acci                                                                                                 | CHIEF MEDICAL EXAMINER                                | _DATE SIGNED             |
| ) | James J Tha h                                                                                                                                          | M. D. ASSISTANT MEDICAL EXAM.                         | 9/22/17                  |
| 3 | 23. BURIAL, CREMATION,   DATE THEREOF   NAME OF CEMETE                                                                                                 | RY OR GREMATORY   LOCATION (City, town, or co         | unty) (State)            |
|   | REMOVAL (Specify) 9-27-55                                                                                                                              | n freh Bolling                                        | md.                      |
|   | DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE                                                                                                            | 24. FUNERAL DIRECTOR                                  | ADDRESS                  |
| ( | List. 26, 1955 C. Harry Teleco                                                                                                                         | Justillo A. Aught- Charles                            | wall med                 |
|   |                                                                                                                                                        |                                                       |                          |

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### CERTIFICATE OF DEATH

Reg. Dist. No. 74

| 1. PLACE OF DEATH:                                                                                                                | 2. USUAL RESIDENCE (HOME) OF DECEASED:                            |                    |
|-----------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|--------------------|
| COUNTY Correll MARYLAND                                                                                                           | STATE MUST COUNTY County                                          | 7                  |
| CITY (If outside corporate limits, write RURAL) LENGTH OF STAY                                                                    | CITY(If outside corporate limits, write RURAL and                 | give nearest town) |
| OR and give nearest town)  Y TOWN  JULES VIELE  June 3 day                                                                        | OR D - 01                                                         | 03 × . 2           |
| HOSPITAL OR Sprupfield State Hospital                                                                                             | STREET ADDRESS 9209 R. Lee A                                      | ve /               |
| 3. NAME OF (First) (Middle) DECEASED: (Type or Print) Evelyn Lee                                                                  | (Last) 4. DATE (Month) (Day OF DEATH: 9 /8                        |                    |
| 5. SEX:   6. COLOR OR   7. SINGLE, MARRIED,   8. DATE   WIDOWED, DIVORCED,   12                                                   | OF BIRTH: 9. AGE last birthday FUNDER I YEAR Months Days          |                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lisual Land                          | 11. BIRTHPLACE (State or foreign country): 12. CI                 | TIZEN OF WHAT      |
| 13 FATHER'S NAME:                                                                                                                 | 14. MOTHER'S MAIDEN NAME:                                         |                    |
| Roland Lee                                                                                                                        | Susamo ?                                                          |                    |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO.                                                               | 17. INFORMANT & ADDRESS:                                          |                    |
| (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                         | Hop tal records                                                   |                    |
| 18. MEDICAL CERTIFICAT                                                                                                            |                                                                   | TERVAL BETWEEN     |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                |                                                                   | NSET AND DEATH     |
| 33/X IMMEDIATE CAUSE (A) (erebook                                                                                                 | l'asculir- acondent                                               | lious              |
| ANTECEDENT CAUSE (8)                                                                                                              | 1 2 5 2 6                                                         | 1000               |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO                                                             | William Steris                                                    | years              |
| STATING UNDERLYING CAUSE LAST.                                                                                                    |                                                                   |                    |
| (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING / R ( )                                                                          | en, 40 th distintence of meto bolom                               |                    |
| TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Provide at M.                                             | with hor, with dense win discose                                  | glas               |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATIO                                                                           | N                                                                 | 20. AUTOPSY?       |
|                                                                                                                                   |                                                                   | YES NO             |
| 21A. ACCIDENT WAS UNDERLYING   CONTRIBUTING   CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER) | story. 21c. WHERE DID (City or town) (County), etc. INJURY OCCUR? | (State)            |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work                                         | D 21F. HOW DID INJURY OCCUR?                                      |                    |
| 22. I hereby certify that I attended the deceased from 1/15                                                                       | , 1955, to 9/18 , 1955, that I last sa                            | aw the deceased    |
| alive on                                                                                                                          | M, from the causes and on the date sta                            |                    |
| 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET                                                                                 | LOCATION (City, town, or ex                                       | ounty) (State)     |
| DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE                                                                                       | 24. FUNERAL DIRECTOR                                              | ADDRESS            |

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.

Supply every item of information carefully. The

VS. A15-10-

CALL OF SHORE AND ALVANDED AND ASSESSED AND STATES DESCRIPTION OF THE PARTY OF THE

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|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Reg. Dist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | No. 26                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| PLACE OF DEATH:   2. USUAL RESIDENCE (HOME) OF DECEASED:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| COUNTY Carroll MARYLAND STATE OMO COUNTY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN  Patapsco    CITY (If outside corporate limits write RURAL and OR TOWN Cleveland)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | d give nearest town)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Tank Road  STREET ADDRESS 12620 E. St. Claira                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| NAME OF (First) (Middle) (Last) 4. DATE (Month) (Day DECEASED: (Type or Print) PATRICK RAY MC CLANAHAN DEATH 9/18/55                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | y) (Year)<br>19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| SEX:   6. COLOR OR   7. SINGLE, MARRIED,   8 DATE OF BIRTII:   9. AGE last birthday:   IF UNDER 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Male White (Specify): Xen . 4. 1910 ) 5 yrs.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Days   Hours   Min.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
| work done during most of work life   AINDUSTRY:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | COUNTRY!                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| even it retired press operator Trober Body Co. Mas Charleston W.Ca.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 4.5.9                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| FATHER'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| 5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS: Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | who when med                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
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| 18. MEDICAL CERTIFICATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | INTERVAL RETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | INTERVAL BETWEEN<br>ONSET AND DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  983× Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s)  Aspiration of blood                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  983× Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s) Diseases or conditions, if any, (b) Aspiration of blood                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  983  Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause  DUE TO  Stating underlying cause last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  983  Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause bat (c) Skull fracture  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  983× Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Skull fracture  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| Immediate cause  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  Da. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ONSET AND DEATH  20. AUTOPSY? Yes □ No □                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Immediate cause  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  Da. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ONSET AND DEATH  20. AUTOPSY? Yes □ No □ (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:    1983                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ONSET AND DEATH  20. AUTOPSY? Yes □ No □                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Skull fracture  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  Da. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:  (a) Subdural and subarachnoid hemorrhage  Aspiration of blood  (b) Aspiration of blood  (c) Skull fracture  (d) THE MEAN OF OPERATION: 19b. MAJOR FINDING OF OPERATION:  (d) TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCUR?  (d) TIME (Month) (Day) (Year) (Hour) 21e. INJURY ONLY while the control of t | 20. AUTOPSY? Yes No (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause of stating underlying cause last (c) Skull fracture  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  Da. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:    County                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 20. AUTOPSY? Yes No (State) Varyland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| Immediate cause  (a) Subdural and subarachnoid hemorrhage  Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Skull fracture  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  DISEASE OR CONDITION CAUSING DEATH  DISEASE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:  OF Street office bldg., etc., INJURY OCCURRED OF DEATH.  DISEASE OF CONDITIONS CONTRIBUTING  DISEASE OF DEATH.  DISEASE OF CONDITIONS CONTRIBUTION OF DEATH OF  | 20. AUTOPSY?   Yes   No     (State)   Waryland     Inquiry     , and ermined cause     .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Immediate cause  (a)  Subdural and subarachnoid hemorrhage  Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause Due To stating underlying cause last (c)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  (a)  DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:  (a)  EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING OF Street office bligs, etc., injury 9/18/55 1:00 PM While at Not while at work Struck over head with piece of the temains described above, held an Autopsy M. Inspection find that death resulted from: Natural causes Accident Accident Deputy Medical Examiner Deputy  | 20. AUTOPSY? Yes   No   (State)   Varyland   No   (State)   No |
| Immediate cause  (a)  Subdural and subarachnoid hemorrhage  Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  (a) DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:  (a) EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING INJURY STREET  (d) TIME (Month) (Day) (Year) (Hour) 21c. INJURY OCCURRED OF INJURY OCCURRED At work Indicate a substantial subarachnoid hemorrhage  (County) 12c. (City or town) (County) OF Street Office blags, etc., Patapsco Carroll  (County) OF Street Office blags, etc., INJURY OCCURRED OF INJURY OCCURRED At work Indicate In | 20. AUTOPSY?   Yes   No   (State)   Waryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| Immediate cause  (a)  Subdural and subarachnoid hemorrhage  Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.  DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:  (a)  EXTERNAL CAUSE WAS PRIMARY TO CONTRIBUTING OF Street chice bligs, etc., 1NJURY STREET  (d)  TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while 1NJURY 9/18/55 1:00 PM Work 1 at work 2 Struck over head with piece of find that death resulted from: Natural causes 1, Accident 1, Suicide 1, Homicide 2, Undete DEPUTY MEDICAL EXAMINER 1 DEPUTY MEDICAL EXAMINER 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 20. AUTOPSY?   Yes   No   (State)   Waryland                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |

BUREAU V. S.

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BECEINED

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| 8999                                                                                                 | CERTIFICAT                                              | TE OF DEATH Reg                                                | Dist. No.                             |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------|----------------------------------------------------------------|---------------------------------------|
| 1. PLACE OF DEATH:                                                                                   |                                                         | 2. USUAL RESIDENCE (HOME) OF DE                                | CEASED:                               |
| COUNTY Carroll                                                                                       | MARYLAND                                                | STATE Maryland COUNTY                                          | City                                  |
| CITY (If outside corporate limits, write I                                                           | URAL LENGTH OF ST.                                      | AY   CITY(If outside corporate limits, write RI                |                                       |
| OR and give nearest town)  Y TOWN Cydcogyrillo                                                       | (in this place)<br>5mo. 28day                           | OR                                                             | 211-1                                 |
| X TOWN Sykesville                                                                                    | 1 5mo. Zoday                                            | STREET (If rural give lo                                       | 5 VO 1-4                              |
| INSTITUTION OR                                                                                       |                                                         | ADDRESS                                                        |                                       |
|                                                                                                      | State Hospital                                          | 924 S. Robinson                                                | Street                                |
| 3. NAME OF (First) DECEASED: (Type or Print) JOSEPH                                                  | (Middie)                                                | (Last) 4. DATE (Month) OF DEATH: SED                           | tember 22 <sub>19</sub> 55            |
| 5. SEX: 6. COLOR OR 7. SINGLE, RACE: WIDOWN (Specific)                                               | MARRIED, 8. DA                                          | TE OF BIRTH: 9. AGE last birthday Mor                          |                                       |
|                                                                                                      |                                                         | 0-15-73 81 yrs.                                                |                                       |
| OA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman | OR INDUSTRY:                                            | II. BIRTHPLACE (State or foreign country) Maryland             | : 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME:                                                                                   |                                                         | 14. MOTHER'S MAIDEN NAME:                                      |                                       |
| Joseph Mewshaw                                                                                       |                                                         | Annie Martin Mewshaw                                           |                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES                                                           | 16. SOCIAL SECURITY NO.                                 | 17. INFORMANT & ADDRESS:                                       |                                       |
| (Yes, no, or unk.) (If Yes, give war or dates of service)                                            |                                                         | Hospital Records                                               |                                       |
|                                                                                                      | IS. MEDICAL CERTIFIC                                    |                                                                | INTERVAL BETWEEN                      |
| I DISEASES OR CONDITIONS DIRECTLY                                                                    | LEADING TO DEATH                                        |                                                                | ONSET AND DEATH                       |
| 420,/                                                                                                | (A) Myocardia                                           | al Infarction                                                  | days                                  |
| ANTECEDENT CAUSE (S'                                                                                 | DUE TO                                                  |                                                                |                                       |
| DISEASES OR CONDITIONS, IF ANY.                                                                      | (B) Coronary                                            | artery occlusion                                               | days                                  |
| GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                        | DUE TO                                                  |                                                                |                                       |
|                                                                                                      | (c) Generalized                                         | d arteriosclerosis& hypertens                                  | ion   years                           |
| TO THE DEATH BUT NOT RELATED TO                                                                      | THE CBS as                                              | ssoc. with disturbance of met                                  | abolism,                              |
| DISEASE OR CONDITION CAUSING D  19A DATE OF OPERATION:   19B. MAJOR                                  | EATH, GROWTH OF I                                       | utrition, with senile brain                                    | disease, Yrs.                         |
| 194. DATE OF OPERATION: 198. MAJOR                                                                   | FINDINGS OF OPERAT                                      | with psychotic reaction                                        | 20. AUTOPSY?                          |
| 21A. ACCIDENT WAS UNDERLYING 21 OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  | B. PLACE (Home, farm,<br>FINJURY street, office blo     | factory. 21c. WHERE DID (City or town) ig., etc. INJURY OCCUR? | (County) (State)                      |
| 21D. TIME (Month) (Day) (Year) (Hour)  <br>OF INJURY M.                                              | 21E INJURY OCCURF<br>While Not while<br>at work at work | RED   21F. HOW DID INJURY OCCUR?                               |                                       |
|                                                                                                      | e deceased from 9-                                      | 1h ,1955, to 9-22 , 1955, that                                 | I last saw the deceased               |
| alive on 9-22, 1955, and signature                                                                   | that death occurred                                     | at 7:40AM, from the causes and on the ADDRESS                  | date stated above.                    |
| They of Journell                                                                                     | uns 9D.                                                 | м. D. Springfield State Hosp.                                  | 9/22/55                               |
| 3. BURIAL, CREMATION, DATE THERES                                                                    | 55 NEW. CATH                                            | HEORAL CEM. 4306 Fred                                          | own, or county) (State)               |
| DATE REC'D BY LOCAL REGISTRAR'S REGISTRAR SUSTEMBLE 24 1955 R.W.                                     |                                                         | Marie Tialkowsky 1000                                          | ADDRESS                               |
| Cyclinger 27 1400 ! 1.W.                                                                             |                                                         | THE WALL WALL TO SE                                            | J. TEMOUDOU G ON                      |

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. MARGIN RESERVED FOR BINDING

correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15-10-53

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|--------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARYLAND STATE DEPARTMENT OF I                                                                                                 |                                                                                                                                                                                                    |
| MEDICAL EXAMINER'S CER                                                                                                         | TIFICATE OF DEATH No.                                                                                                                                                                              |
| 1. PLACE OF DEATH:                                                                                                             | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                                                                                                                             |
| COUNTY Carroll MARYLAND                                                                                                        | STATE Maryland COUNTY Carroll                                                                                                                                                                      |
| CITY (If outside corporate limits, write RURAL OR and give pearest town) TOWN Rural, Nr. Westminster  Life                     | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rural, Nr. Westminster                                                                                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Westminster, Md. R.D.1                                                               | STREET (If rural, give location)  ADDRESS Westminster, Md. R.D.1                                                                                                                                   |
|                                                                                                                                | (Last) 4. DATE (Month) (Day) (Year) OF DEATH Sept. 14 1955                                                                                                                                         |
| Female White Whowed 6/5                                                                                                        | 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  1873   9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.  Months Days Hours Min.                                                      |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, Housewifteretiffousework Hor own home                  | Carroll Co., Md. U.S.A.                                                                                                                                                                            |
| 13. FATHER'S NAME:                                                                                                             | 14. MOTHER'S MAIDEN NAME:                                                                                                                                                                          |
| Joahua Engleman                                                                                                                | Sarah Nickey                                                                                                                                                                                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (1f Yes, give war or dates of NO. 217-12-1320A                  | "Mrs. Elmer Messinger, Alesia, Millers; Md.                                                                                                                                                        |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  Immediate cause  (a) Oromony  DUE TO                                     | AL CERTIFICATION  INTERVAL BETWEEN ONSET AND DEATH                                                                                                                                                 |
| Antecedent cause(s)  Diseases or conditions, if any, (b)  giving rise to the above cause DUE TO  stating underlying cause last |                                                                                                                                                                                                    |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                  |                                                                                                                                                                                                    |
| TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                        |                                                                                                                                                                                                    |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                                       | 20. AUTOPSY? Yes □ No □                                                                                                                                                                            |
| 21a. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   OF street, office bldg., etc., CAUSE OF DEATH.                             |                                                                                                                                                                                                    |
| 21d. TIME (Month) (Day) (Year) (Hour) 21e. INJURY OCCURRED While at Not while INJURY M. work \[ \] at work \[ \]               | 21f. HOW DID INJURY OCCUR?                                                                                                                                                                         |
| find that death resulted from: Natural causes B, Accidental SIGNATURE                                                          | ded above, held an Autopsy , Inspection , Inquiry , and lent , Suicide , Homicide , Undetermined cause .  CHIEF MEDICAL EXAMINER DATE SIGNED DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. |
| 23. BURIAL, CREMATION, PATE THEREOF NAME OF CEMETER Burial 7/17/55 Methodist Cemeter                                           |                                                                                                                                                                                                    |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REG. 7-15-50 Hamit Muller                                                            | 24. FUNERAL DIRECTOR  ADDRESS  Little Stown, Pa.                                                                                                                                                   |
|                                                                                                                                | Ru R. A - Little Partner                                                                                                                                                                           |

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.Dr. pero ELEY LAZUALL JENG DERON, FRANKER .ONA E. F.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 8558

CERTIFICATE OF DEATH

Reg. Dist. No. 75

| I. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                     | 2                      |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|------------------------|
| COUNTY Canall MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STATE Mary Canal COUNT                                                     | y trechest             |
| CITY (If outside corporate limits, write RURAL LENGTH OF STAY OR and rive nearest town)  TOWN TOWN 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                            |                        |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS ING VIEW Musing Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET (If rurai give location)                                            | X-2 N                  |
| 3. NAME OF DECEASED: (Middle) (Type or Print)  2446  ESTELLE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (Last) 4. DATE (Month) (Day) OF DEATH: Stude 23                            | (Year)                 |
| S. SEX:  S. COLOR OR RACE:  Wildowed, Divorced, (Specify) Sunfo Dec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | OF BIRTH:  9. AGE last birthday: If UNDER 1 YEA  Months Day                |                        |
| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | R II. BIRTHPLACE (State or foreign country): 12. CI                        | TIZEN OF WHA           |
| 13. FATHER'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME:                                                  |                        |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: 17. Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Mrs Thelma Frock. Walkerfill                                               | 1 mg                   |
| 18. MEDICAL CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ION                                                                        | Intervai Between       |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH  Immediate cause  (a)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | myoearditis.                                                               | Onset And Dear         |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.  DUE TO  DUE TO  DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | En Cardis-Voccolu deserse                                                  |                        |
| I. OTHER SIGNIFICANT CONDITIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                        |
| Conditions contributing to the death but not related to the disease or condition causing death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                            |                        |
| 9a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                            | 20. AUTOPSY ?          |
| I. ACCIDENT (Specify)   PLACE (Home, farm, factory, street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | t, (CITY OR TOWN) (COUNTY) (ST                                             |                        |
| SUICIDE OF office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                            | ATE)                   |
| SUICIDE OF office bidg., etc.)  INJURY  TIME (Month) (Day) (Year) (Hour)   INJURY OCCURED OF While at Not While                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | HOW DID INJURY OCCUR?                                                      |                        |
| SUICIDE OF office bldg., etc.)  HOMICIDE INJURY  TIME (Month) (Day) (Year) (Hour) INJURY OCCURED While at Not While                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | How did injury occur?  3,1953, to Juff 23, 1955, that I last s             | ATE)                   |
| SUICIDE OF office bldg., etc.)  HOMICIDE INJURY  TIME (Month) (Day) (Year) (Hour) INJURY OCCURED While at Not While INJURY OF At Work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                            | aw the decease         |
| SUICIDE  HOMICIDE  TIME (Month) (Day) (Year) (Hour)  OF  INJURY  TIME (Month) (Day) (Year) (Hour)  While at  Not While  Work At Work  22. I keepby certify that I attended the deceased from  Alive on the Courted at  SIGNATURE  3. BURNAL, CREMATION   BATE THEREOF   WAME OF CEMETE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 7 A.M., from the causes and on the date st<br>ADDRESS  Hawfoling M. M.     | aw the deceased above. |
| SUICIDE  HOMICIDE  TIME (Month) (Day) (Year) (Hour)  OF INJURY  TIME (Month) (Day) (Year) (Hour)  OF INJURY  The work At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At Work  At | 7 A, M, from the causes and on the date st<br>ADDRESS  Howhole of Mod Sign | aw the deceased above. |

BOYEVI A W

14 - 6

2Eb 30 1822

DECENCED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The

VS. A15.

#### 08562 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 8559

| CITATA | TIFIC | A FINTS      | OTA   | TATA     | FESTER |
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| Dom  | Diet  | NT- | 24   |
|------|-------|-----|------|
| neg. | Dist. | NO. | 1. / |

| Jy.                       | 1. PLACE OF DEATH:                                                                                                                                                                               | 2. USUAL RESIDENCE (HOME) OF DECEASED:  STATE Maryland COUNTY  CITY(If outside Maporate limits, write RURAL and give nearest town) |                 |  |  |  |
|---------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------|-----------------|--|--|--|
| death clearly and legibly | COUNTY Carroll MARYLAND                                                                                                                                                                          |                                                                                                                                    |                 |  |  |  |
| le                        | CITY (If outside corporate limits, write RURAL) LENGTH OF STAY                                                                                                                                   |                                                                                                                                    |                 |  |  |  |
| nd                        | OR and give nearest town) TOWN Sykesville pucce 3-27-51                                                                                                                                          | place) OR TOWN Baltimore 240                                                                                                       |                 |  |  |  |
| N N                       | HOSPITAL OR                                                                                                                                                                                      | STREET (If rural give location)                                                                                                    | V 01-4          |  |  |  |
| rr                        | INSTITUTION OR                                                                                                                                                                                   | ADDRESS                                                                                                                            |                 |  |  |  |
| les                       |                                                                                                                                                                                                  |                                                                                                                                    | V               |  |  |  |
| h                         |                                                                                                                                                                                                  | (Last) 4. DATE (Month) (CAST) OF Sept. Q                                                                                           | Day) (Year)     |  |  |  |
| eat                       | (Type or Print) Margareth Stuona                                                                                                                                                                 | DEATH:                                                                                                                             | 19              |  |  |  |
|                           | 5. SEX:   6. COLOR OR   7. SINGLE, MARRIED,   8. DATE   WIDOWED, DIVORCED.                                                                                                                       | 9-1904. 9. AGE last birthday IF UNDER 1                                                                                            |                 |  |  |  |
| Jo:                       | (Specify):                                                                                                                                                                                       | 9-1.904, wrs. Months I                                                                                                             | Days Hours Min. |  |  |  |
| causes                    | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):                                                                                                     | 11. BIRTHPLACE (State of foreign country):  12.                                                                                    | CITIZEN OF WHAT |  |  |  |
| an                        |                                                                                                                                                                                                  |                                                                                                                                    | COUNTRY?        |  |  |  |
|                           | housewife                                                                                                                                                                                        | 14. MOTHER'S MAJOEN NAME:                                                                                                          | U.S.A.          |  |  |  |
| the                       |                                                                                                                                                                                                  |                                                                                                                                    |                 |  |  |  |
| write                     | John Petersen 18. Was Deceased Ever in U.S. Armeo Forcest   16. Social Security No.                                                                                                              |                                                                                                                                    |                 |  |  |  |
| W                         | (Yes, no, or unk.) (If Yes, give war or dates                                                                                                                                                    | Hospital                                                                                                                           |                 |  |  |  |
| Se                        | Id no of service)                                                                                                                                                                                |                                                                                                                                    |                 |  |  |  |
| please                    | 18. MEDICAL CERTIFICATI                                                                                                                                                                          | INTERVAL BETWEEN                                                                                                                   |                 |  |  |  |
| Q                         | T DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                               |                                                                                                                                    | ONSET AND DEATH |  |  |  |
| Physicians:               | IMMEDIATE CAUSE (A) COPONARY OF                                                                                                                                                                  | few minut                                                                                                                          |                 |  |  |  |
|                           | IMMEDIATE CAUSE (A) Coronary occlus ion  ANTECEDENT CAUSE (S)  DUE TO                                                                                                                            |                                                                                                                                    |                 |  |  |  |
| sic                       | DISEASES OR CONDITIONS, IF ANY. (B) Hypertensive cardiovascular disease                                                                                                                          |                                                                                                                                    |                 |  |  |  |
| hy                        | GIVING RISE TO THE ABOVE CAUSE DUE TO                                                                                                                                                            |                                                                                                                                    |                 |  |  |  |
|                           | STATING UNDERLYING CAUSE LAST.                                                                                                                                                                   |                                                                                                                                    |                 |  |  |  |
| important.                | (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                                                                                 |                                                                                                                                    |                 |  |  |  |
| rta                       | TO THE DEATH BUT NOT RELATED TO THE                                                                                                                                                              | Melancholia                                                                                                                        | 5 years         |  |  |  |
| odi                       | DISEASE OR CONDITION CAUSING DEATH. Throlution 1                                                                                                                                                 |                                                                                                                                    |                 |  |  |  |
| im                        | 198. DATE OF OPERATION:                                                                                                                                                                          |                                                                                                                                    | 20. AUTOPSY?    |  |  |  |
| الم                       |                                                                                                                                                                                                  |                                                                                                                                    | YES NO Z        |  |  |  |
| especially                | 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory, 21c. WHERE DID (City or town) (County) (State) OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc.   INJURY OCCUR? |                                                                                                                                    |                 |  |  |  |
| bec                       | (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                             |                                                                                                                                    |                 |  |  |  |
| esi                       | 21b. TIME (Month) (Day) (Year) (Hour) 21g INJURY OCCURRED 21f. HOW DID INJURY OCCUR? While Not while                                                                                             |                                                                                                                                    |                 |  |  |  |
| 20                        | M.   at work   at work                                                                                                                                                                           |                                                                                                                                    |                 |  |  |  |
|                           | 22. I hereby certify that I attended the deceased from March 27, to Sept. 9, 1955, that I last saw the deceased                                                                                  |                                                                                                                                    |                 |  |  |  |
| 200                       | 22. I hereby certify that I attended the deceased from March 27, to 19, that I last saw the deceased                                                                                             |                                                                                                                                    |                 |  |  |  |
| ct                        | SIGNATURE SIGNATURE DATE SIGNED                                                                                                                                                                  |                                                                                                                                    |                 |  |  |  |
| correct                   | Sykesville, Md Sept. 9,1955                                                                                                                                                                      |                                                                                                                                    |                 |  |  |  |
| CO                        | 23 BURIAL CREMATION, DATE THEREOF   NAME OF CEMETERY OR CREMATORY   LOCATION (City, town, or county) (Sta                                                                                        |                                                                                                                                    |                 |  |  |  |
|                           | REMOVAL (SPECIFY)                                                                                                                                                                                |                                                                                                                                    |                 |  |  |  |
|                           | Burial Sept. 13, 1955 Moreland Mem. Park Baltimore, Maryland DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE   24. FUNERAL DIRECTOR ADDRESS                                                          |                                                                                                                                    |                 |  |  |  |
|                           | REGISTRAR 1955 P. ALGARAN TILLIAN                                                                                                                                                                |                                                                                                                                    |                 |  |  |  |

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

8560

# CERTIFICATE OF DEATH

| FOR MEDICAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>EXAMINERS</b>                | Reg. Dist.                                  | No. 82                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------|---------------------------------------------|-------------------------------------------------------|
| 1. PLACE OF DEATH- COUNTY MARYLAND MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 2. USUAL RESIDENCE ( STATE HARY | road cour                                   | MITTILL.                                              |
| CITY (If outside corporate limits, write RURAL and Corporate limits, write | TOWN / lee Th                   | Ate limits, write RURAL and                 | X                                                     |
| INSTITUTION OR Thair &.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS                  | (If rural, give location)                   |                                                       |
| 3. NAME OF DECEASED (First) (Meldie) (Type or Print) HOWARD                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ARMS.                           | 4. DATE (Month) OF DEATH Sept               | (Day) (Year)<br>22 19J3                               |
| 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WITCH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 6. DATE OF BIRTH  Out 4-1873.   | () / yrs.                                   | er 1 year   If under 24 hrs. hs   Days   Hours   Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10 No. 1  | 11. BIRTHPLACE (State           | onl_                                        | Citizen of What                                       |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 | Carrow                                      | 4                                                     |
| 15. WAS DECRASED EVEN IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 17. INFORMANT AND               | Tona needle                                 | under the                                             |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | RTIFICATION                     |                                             | INTERVAL BETWEEN<br>ONSET AND DEATH                   |
| 420 Immediate cause (a) Shyrconic                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | e Sufar                         | lion                                        | Nacer -                                               |
| Antecedent cause(s)  Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | /                               |                                             |                                                       |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                 |                                             |                                                       |
| 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 |                                             | 20. AUTOPSY1                                          |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING OF office bldg., etc.) CAUSE OF DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (CITY OR                        | TOWN) (COUNT                                | Y) (STATE)                                            |
| TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED While at Not whife work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | HOW DID INJURY OC               | CUR?                                        |                                                       |
| 22. I certify that I took charge of the remains described above, held an A obtained by said Autopsy, Inspection or Inquiry, find that said deceafrom: natural causes accident, suicide, homicide, SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | atate up h and and hach have    | Inquiry I thereon and above, and death in m | d from the evidence y opinion resulted                |
| 23. BURIAL CREMATION DATE THEREOF NAME OF CEMETER PENLOVAL (Sprendy)  9125155                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Xaunie 1000<br>TY OR CREMATORY  | OCATION (City, town, or con                 | 11 7 2 4 50 - (State)                                 |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 24. FUNERAL DIRECTO             |                                             | ADDRESS                                               |

BECEINED

BUREAU V. S.

SEP 28 1955

The correct age

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MARGIN RESERVED FOR BINDING

# CERTIFICATE OF DEATH

| COL                                                                                        | 8561                                                                                                                                                                                                                                                                                                                                                                                         | FOR MEDICAL                                                                                                                                                                                                                                                      | EXAMINERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Reg. Dis                                  | 1. No. Se                                                     |
|--------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------------|
| n carefully. The                                                                           | I. PLACE OF DEATH COUNTY  CITY (If outside corporate limits, write RURA) OR give nearest town) TOWN  HOSPITAL OR INSTITUTION OR STREET ADDRESS                                                                                                                                                                                                                                               | MARYLAND Land   LENGTH OF STAY (in this place)                                                                                                                                                                                                                   | 2. USUAL RESIDENCE (H<br>STATE)  CITY (If outside corpora<br>OR<br>TOWN  STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                           | E X                                                           |
| Supply every item of information carefully, write the causes of death clearly and legibly. | 10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  13. FATHER'S NAME  15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of                                                                                                                                                                            | (Middle)  ARRIE  7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)  10b. Kand of Business or Industry  16. Social Security No.                                                                                                                                    | (Last)  ECRU  8. DATE OF BIRTH  4. 3  11. BIRTHPLACE (State of Manual Action of Manual Acti | foreign country)                          | 1907                                                          |
| UNFADING INK. Supply                                                                       | I. DISEASES OR CONDITIONS DIRECTLY L  774/Immediate cause  Antecedent cause(s)  Diseases or conditions, if any, giving rise to the shove cause stating the underlying cause last  (c)  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not                                                                                                                         | 18. MEDICAL CE                                                                                                                                                                                                                                                   | y The ness                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                           | INTERVAL BETWEE ONSET AND DEATH                               |
| WRITE PLAINLY, WITH is especially importan                                                 | related to the disease or condition causing death.  19a. DATE OF OPERATION 19b. MAJOR FI  21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING OF CAUSE OF DEATH.  TIME (Month) (Day) (Year) (Hour) OF INJURY 9 STORY m.  22. I certify that I took charge of the remain obtained by said Autopsy, Inspection or from: noturol causes , occident , SIGNATURE  23. BURIAL, CREMATION   DATE THEREOI | NDINGS OF OPERATION  E (Home, farm, factory, atreet, office, bidg., etc.)  RY  INJURY OCCURRED  While at Not while work at work at work  ns described obove, held an A Inquiry, find that said decessuicide , homicide , (Degree or title)  Depute, Thesical Lea | osed died on the day stated undetermined ADDRESS  Muiu - Weshu                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | Inquiry of thereon of above, and death in | and from the evidence my opinion resulted  DATE SIGNED  9//53 |
| PLEASE                                                                                     | DATE REC'D BY LOCAL REGISTRAR'S S REG. 2-1-1-1                                                                                                                                                                                                                                                                                                                                               | 5 Generalia                                                                                                                                                                                                                                                      | 24 FUNERAL DIRECTOR                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | toler 7.                                  | ADDRESS                                                       |

BUREAU V. S.

SEP 6 1955

BECEINED

The correct age

8562

#### MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

08565

| 0                                                                                         |                                                                                                                 |                          |                                 |                                                 |  |  |
|-------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------|---------------------------------|-------------------------------------------------|--|--|
| The                                                                                       | 1. PLACE OF DEATH.                                                                                              | 2. USUAL RESIDENCE (H    |                                 |                                                 |  |  |
| -                                                                                         | 1. PLACE OF DEATH. COUNTY Carroll MARYLAND CUTY (It quiside corporate limits, write RURAL and 1 LENGTH OF STAY) | STATE Maryland           | Count                           | 2011                                            |  |  |
| ×:                                                                                        |                                                                                                                 | CITY (If outside corpora | te limits, write RURAL and gi   |                                                 |  |  |
| ull                                                                                       | Y TOWN RWI, Raneytown (in this place)                                                                           | TOWN Route #1            | Tanevtown                       | X                                               |  |  |
| 9 . go                                                                                    | HOSPITAL OR                                                                                                     | STREET                   | (If rural, give location)       |                                                 |  |  |
| ES I                                                                                      | INSTITUTION OR                                                                                                  | ADDRESS                  | (2.12.4)                        |                                                 |  |  |
| n a                                                                                       | OTO STREET ADDRESS                                                                                              | (1)                      | L. Dien de                      | (7)                                             |  |  |
| y s                                                                                       | 3, NAME OF (First) (Middle) DECEASED                                                                            | (Last)                   | 4. DATE (Month)                 | (Day) (Year)                                    |  |  |
| arl                                                                                       | (Type or Print) Ida Rebecca                                                                                     | Phillips                 | DEATH Sept.                     | 11, 19 55                                       |  |  |
| cle                                                                                       | 5. SEX   6. COLOR OR RACE   7. SINGLE, MARRIED, WIDOWED DIVORCED                                                |                          | 9. AGE last birthday   If under | I year   If under 24 hrs.   Days   Hours   Min. |  |  |
| in d                                                                                      | Female White WIDOWED, DIVORCED, (Specify) Widow                                                                 | Jan. 1, 1865             | 90 ym. l                        | Days Louis Min.                                 |  |  |
| of                                                                                        | 10a. USUAL OCCUPATION (Give kind of work   10b. Kind of Business or                                             | 11. BIRTHPLACE (State or | foreign country) 12             | COUNTRY?                                        |  |  |
| G.                                                                                        | done during most of working life, even if retired) INDUSTRY NOUSEWORK OWN home                                  | Maryland                 |                                 | U.S.A.                                          |  |  |
| 3 o                                                                                       | 13. FATHER'S NAME                                                                                               | 14. MOTHER'S MAIDEN      | NAME                            |                                                 |  |  |
| See 1                                                                                     | William Nusbaum                                                                                                 | Lvdia Hesso              | n                               |                                                 |  |  |
| au                                                                                        | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.                                           | 17. INFORMANT AND        | ADDRESS                         |                                                 |  |  |
| e c                                                                                       | (Yes, no, or unknown) (If yes, give war or dates of none                                                        |                          | merman, Taneytow                | n Maryland                                      |  |  |
| th                                                                                        | no leervice) l none                                                                                             |                          | mer man, raney cow              | i wai yianu                                     |  |  |
| Supply every item of information carefully write the causes of death clearly and legibly. |                                                                                                                 | RIFICATION               |                                 | INTERVAL BETWEEN<br>ONSET AND DEATH             |  |  |
| Su                                                                                        | I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                             |                          |                                 |                                                 |  |  |
| via 100 Immediate cause (a) Cerebro-Vascular Accident                                     |                                                                                                                 |                          |                                 |                                                 |  |  |
| ea K                                                                                      | 199   Immediate cause (a) CEPERFO-VOSCO                                                                         | CIAP JISSINS             |                                 | 16 days                                         |  |  |
| Ha                                                                                        | Antecedent cause(s)                                                                                             | T -                      | (                               | 7 20                                            |  |  |
| 0 3                                                                                       | Diseases or conditions, if any, (b) South and C.E. Was                                                          |                          | lue /b                          | 2 5 days                                        |  |  |
| Zig                                                                                       | giving rise to the above cause stating the underlying cause last Abdoutus Mali                                  | quoncy                   |                                 | 0                                               |  |  |
| D's                                                                                       | Stating the underlying cause last                                                                               | n Date vin               | sclerolic                       | -                                               |  |  |
| FA                                                                                        |                                                                                                                 |                          |                                 |                                                 |  |  |
| ZA                                                                                        | Conditions contributing to the death but not related to the disease or condition causing death.                 |                          |                                 |                                                 |  |  |
| WRITE PLAINLY, WITH UNFADING INK. is especially important. Physicians: please             | 19a, DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATION                                                       |                          |                                 | 20. AUTOPSY?                                    |  |  |
| Har                                                                                       | No.                                                                                                             |                          |                                 |                                                 |  |  |
| II                                                                                        | 21. ACCIDENT (Specify)   PLACE (Home, farm, factory, street,                                                    | : (CITY OR T             | OWN) (COUNTY                    | Yes No W                                        |  |  |
| WITH                                                                                      | SUICIDE OF office bldg., etc.)                                                                                  |                          | (0001111                        | (011112)                                        |  |  |
| 54.5                                                                                      | HOMICIDE INJURY TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED                                                | I HOW DID INJURY OCC     | TIP?                            |                                                 |  |  |
| 177                                                                                       | OF While at Not While                                                                                           | HOW DID INSURT OCC       | JOKI                            |                                                 |  |  |
| Z.                                                                                        | INJURY m.   Work   At work                                                                                      |                          |                                 |                                                 |  |  |
| Spe                                                                                       | 22. I hereby certify that I attended the deceased from Aug                                                      | 1055 to 90 AT            | // 1055 that I last             | now the deceased                                |  |  |
| PI                                                                                        | 22. I hereby certify that I attended the deceased from many                                                     | , 19.2.2., 10.00.00,00   | .x, 19, that I last a           | saw the deceased                                |  |  |
| 国.日                                                                                       | alive on Sept. 4, 19.65, and that death occurred at.                                                            | .:/D. A. m. from the     | causes and on the date st       | ated above.                                     |  |  |
| L                                                                                         | SIGNATURE (Degree or title)                                                                                     | ADDRESS                  |                                 | DATE SIGNED                                     |  |  |
| 24                                                                                        |                                                                                                                 | 7 7                      | 0                               | 0 1000                                          |  |  |
|                                                                                           | E. aublest Thompson M.D.                                                                                        | loneylow                 |                                 | 9-12-55                                         |  |  |
|                                                                                           | DUNGOVA (Const.)                                                                                                |                          | OCATION (City, town, or coun    |                                                 |  |  |
| AS                                                                                        | Burial (Specify) Sept.14.1955 Baust Ceme                                                                        | etery                    | Tyrone, Carroll 6               | o. Maryland                                     |  |  |
| PLEASE                                                                                    | ODATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE                                                                    | 24. FUNERAL DIRECTO      | R                               | ADDRESS                                         |  |  |
| PI                                                                                        | 18 75 12 1933 T The 11 Mehreno                                                                                  | C.O. Fuss & Son.         | . Tanevtown. Mary               | land                                            |  |  |

C.O.Fuss & Son, Taneytown, Maryland

VS. A15

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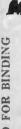
BUREAU V

## 8563

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

| 1. PLACE OF DEATH COUNTY                                                                                                           | 2. USUAL RESIDENCE (HOME) OF DECEASED.                          | V Marrie                                |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------|
| MARYLAND                                                                                                                           | MANYAMED                                                        | CHANDA                                  |
| CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town)                                            | CITY (If outside corporate limits, write RURAL and give OR TOWN | re nearest town)                        |
| HOSPITAL OR                                                                                                                        | STREET (If rural, give location)                                | 7                                       |
| INSTITUTION OR MINIERAL HILL KD                                                                                                    | ADDRESS MINERAL HILL KO                                         |                                         |
| 3. NAME OF (First) DECEASED (Type or Print) LILLIAN (CLLY) N                                                                       | CHARDSON OF SEPT.                                               | (Day). (Year)                           |
| 6. COLOR OR RACE 7. SINGLY, MARRIED, DIVORCED, (Specify)                                                                           | 8. DATE OF BIRTH 9. AGE last birthday Months.                   | 1 year If under 24 hr<br>Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  INDUSTRY                              |                                                                 | COUNTRY?                                |
| 13. FATHER'S NAME                                                                                                                  | 14. MOTHER'S MAIDEN NAME                                        |                                         |
| JOHN K. KICHAKDSON                                                                                                                 | TRANCES F. YRMY                                                 |                                         |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If year, give war or dates of service). | 17. INFORMANT AND ADDRESS                                       | CUILLE                                  |
|                                                                                                                                    |                                                                 |                                         |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                | RTIFICATION                                                     | INTERVAL BETWEEN<br>ONSET AND DEATH     |
| 4 43 X Immediate cause (a) CONGESTIVE HE                                                                                           | ART FAILURE (ACUTE) &                                           | 2 0445                                  |
| Antecedent cause(s)                                                                                                                | and                                                             |                                         |
| Diseases or conditions, if any, (b)                                                                                                | - C.V. DISTASE - E                                              | 10 VEDES                                |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.   | <i>Y</i> -                                                      | 1.32 j. F 1.1600 1                      |
| 19a. DATE OF OPERATION   19b. MAJOR FINDINGS OF OPERATION                                                                          |                                                                 | 20. AUTOPSY?                            |
|                                                                                                                                    |                                                                 | Yes No D                                |
| 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office hidg., etc.) HOMICIDE INJURY                                  | (CITY OR TOWN) (COUNTY)                                         | (STATE)                                 |
| TIME (Month) (Day) (Year) (Hour)   INJURY OCCURRED   While at Not While   Not Work   At work                                       | HOW DID INJURY OCCUR?                                           |                                         |
| 22. I hereby certify that I attended the deceased from HIKIL                                                                       | ., 1953, to SEPT 9, 1955, that I last s                         | aw the deceased                         |
| LEPT 9 CT VILLE                                                                                                                    | 57.3.6. P.m., from the causes and on the date st                | ated shave                              |
| alive on the sign and that death occurred at                                                                                       | ADDRESS / // ADDRESS / //                                       | DATE SIGNED                             |
| Mesual C. Mulle 1110-                                                                                                              | Laudall slown-14d-                                              | 9-4755                                  |
|                                                                                                                                    | RY OR GREMATORY   LOCATION (City, town, or coun                 | ty) (State)                             |
| BEMOVAL (Specify) 9-12-55 Officer                                                                                                  | full Ofmesville.                                                | ma.                                     |
| DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE                                                                                        | 24. EUNERAL DIRECTOR                                            | ADDRESS                                 |



194



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BUREAU V. S.

A CONTRACTOR OF THE

175

(Year)

Hours

Interval Between

Onset And Death

20. AUTOPSY ?

Yes | No |

days.

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ADDRESS

LOCATION (City, town, or county).

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23. BURIAL, CREMATION.

REMOVAL , (Specify) DATE REC'D BY LOCAL

1. PLACE OF DEATH: 2. USUAL RESIDENCE (HOME) OF DECEASED: Carroll STATE Maryland COUNTY COUNTY Montgomery MARYLAND CITY (If outside corporate limits, write RURAL LENGTH OF STAY CITY (If outside corporate limits, write RURAL and give nearest town) OR and give nearest town)
TOWN Sykesville (in this place) OR TOWN Chevy Chase HOSPITAL OR INSTITUTION OR STREET (If rural give location) Springfield State Hospital. ADDRESS Lynn Drive STREET ADDRESS 3. NAME OF (First) (Middle) (Last) 4. DATE (Month) (Day) DECEASED: Nellie 18 Robinson Sept. (Type or Print) DEATH: 5. SEX: s. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, 8. DATE OF BIRTH: 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. RACE: Months Days (Specify): Widowed Female 2-28-76 10a. USUAL OCCUPATION. Give kind of 10b. KIND OF BUSINESS OR | 11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT work done during most of working life, INDUSTRY: COUNTRY? even if retired): Unknown Indiana 13. FATHER'S NAME: 14. MOTHER'S MAIDEN NAME: William Elliot Namcy Andamile 17. INFORMANT & ADDRESS: Mr. Myles Robinson (son) 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY No.: (Yes, no, or unk.) (If Yes, give war or dates of 7505 Lynn Drive, Chevy Chase, Md. service) No 18. MEDICAL CERTIFICATION 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 (a) ..... Myocardial infarction. Immediate cause DUE TO Antecedent causes (s) Coronary artery thrombosis Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last. DUE TO Generalized arteriosclerosis and Hypertension Chronic Brain syndrome, with cerebral arteriosclero- months 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not Conditions contributing to the death but not related to the disease or condition causing death, sis and psychotic reactions—Bronchopneumonia————days 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, (CITY OR TOWN) (COUNTY) (STATE) SUICIDE OF office bldg., etc.) HOMICIDE INJURY TIME (Month) (Day) (Year) (Hour) INJURY OCCURED HOW DID INJURY OCCUR? While at Not While INJURY Work [ At Work 22. I hereby certify that I attended the deceased from 8-26-.....1955 to 9- 18- 19.55, that I last saw the deceased alive on 9-18-, and that death occurred at \$550.p.m., from the causes and on the date stated above. SIGNATURE Springfield State Hospital. 9-18-55

NAME OF CEMETERY OR CREMATORY

FUNERAL DIRECTOR

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Letters armin three east of the contract of th

## BUREAU V. S.

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age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY

VS.

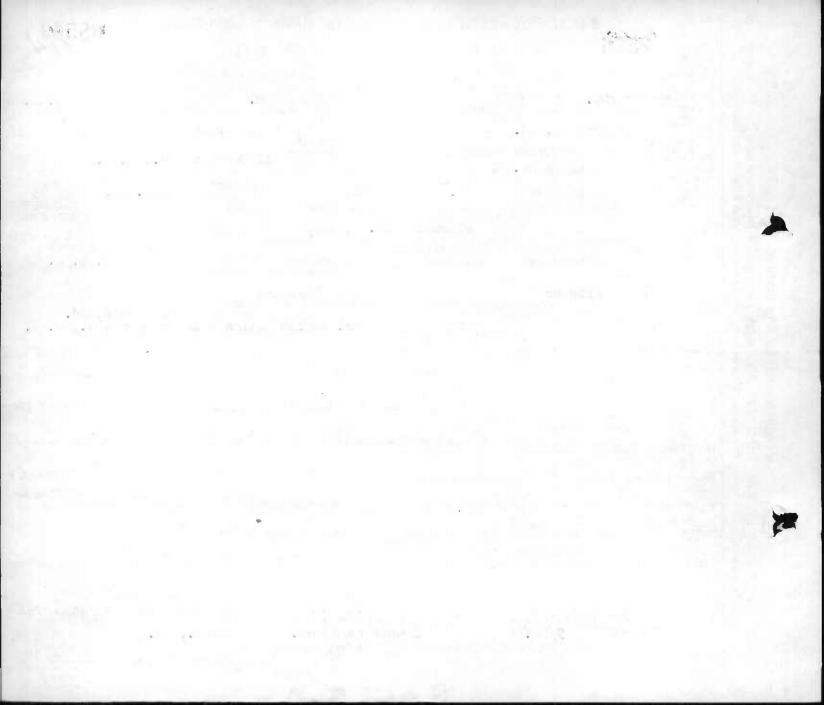
### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8566 CF

#### CERTIFICATE OF DEATH

Reg. Dist. No. 74

|                                     |                                           |               |                                |              |                         |                        | reg.              | Dist. 110.   |                             |
|-------------------------------------|-------------------------------------------|---------------|--------------------------------|--------------|-------------------------|------------------------|-------------------|--------------|-----------------------------|
| I. PLACE                            | OF DEATH:                                 |               |                                |              | 2. USUAL RESII          | DENCE (HOM)            | E) OF DECEAS      | ED:          |                             |
| COTINES                             |                                           | arrol         | //                             |              |                         |                        |                   |              |                             |
| COUNTY CITY (14                     |                                           |               | RURAL LENGTH O                 | ND -         |                         | Md.                    | imits, write RU   | COUNTY       | A. A.                       |
| OR an                               | d give nearest town)                      |               | (in this                       | place)       | OR                      |                        |                   | KAL and give | nearest town)               |
| HOSPITA                             | Eldersburg                                | Ma.           |                                |              | u.                      | len Burni              |                   | 0            | of X m one                  |
| INSTITU                             | TION OR Gran                              | dview         | Mansion                        |              | STREET<br>ADDRESS       |                        | (If rural give le |              | 1                           |
| 10 STREET                           | ADDRESS                                   | e No.         |                                |              |                         | 12 Georgi              | a Ave.,           | N. W.        | ٧                           |
| 3. NAME OF<br>DECEASE<br>(Type or I | D: PATIT                                  | INE           | (Middle)                       | RUMME        | Last)                   | 4. DATE<br>OF<br>DEATH | (Month)<br>Sept.  | 77           | (Year)<br>19 55             |
| 5. SEX:                             | S. COLOR OR RACE:                         | 7. SING       | LE, MARRIED,                   | B. DATE OI   | BIRTH:                  | 9. AGE last            | birthday: if UN   |              |                             |
| F                                   | W.                                        | (Speci        | WED, DIVORCED,<br>fy): widowed | Oct. 2       | . 1876                  | 78                     | yrs. Mont         | ths Days H   | ours Min.                   |
| IOa. USUAL                          | OCCUPATION. Give                          | kind of       | 10b. KIND OF BUSI              |              |                         | E (State or fe         | oreign country):  | 12. CITIZE   | N OF WHAT                   |
| work don                            | ne during most of wor<br>retired): Housey |               | at home                        |              | Germany                 |                        |                   | COUNT        |                             |
| I3. FATHER'                         |                                           | 4710          | a o monte                      |              | 4. MOTHER'S MA          | IDEN NAME:             |                   | U. S.        | A .                         |
|                                     |                                           |               |                                | 1            |                         |                        |                   |              |                             |
| 15 Was Desce                        | ? Kriege                                  |               | 1 10 0                         | 77 1 1 0 T   | Unknown                 |                        |                   |              |                             |
| (Yes, no, or u                      | nk.)   (If Yes, give wa                   | r or dates of | 16. SOCIAL SECURITY            | No.: 17. 1   | NEURMANT & A            | DURESS:                | Glen Bur          | rnie. Md     |                             |
| 16 no                               | service)                                  |               | none                           | M:           | r. Adolph l             | Nethen -               | 12 Georgi         | ia Ave.      | N.W.                        |
|                                     |                                           |               | 18. MEDICAL CERT               | TIFICATION   | V                       |                        |                   |              |                             |
| I. DISEASE                          | S OR CONDITIONS                           | DIRECTL       | Y LEADING TO DEA               | TH           |                         |                        |                   |              | erval Between set And Death |
| 11. 3                               | 20.0                                      |               | 0 1.                           | •            | 0 .                     | 6 0                    |                   | Oil          | A Death                     |
| Immedi                              | iate cause                                | (а            | ) Lynnton                      | sure c       | or dio von              | who de                 | سسيمد             | 24           | malgran                     |
| Anteco                              | dent causes (s)                           | DUE           | Reputer                        |              |                         |                        |                   |              | 0                           |
| Diseases                            | or conditions, if ar                      | ıy, (h        | atterios.                      | lent         | cheat d                 | lesand                 |                   | ne           | waly son                    |
| giving r<br>stating t               | ise to the above cau                      |               | TO                             |              | 4 0                     |                        |                   |              |                             |
|                                     |                                           | (c            | Andreas                        | 40 004       | ilo chase               | Comme .                |                   |              |                             |
| 11. OTHER S                         | SIGNIFICANT COND                          | ITIONS        |                                |              | TITC PROPERTY           | 4-~                    |                   | 1            |                             |
| Condition                           | s contributing to the                     | death but     |                                |              |                         |                        |                   |              |                             |
|                                     |                                           |               | FINDINGS OF OPER               | RATION       |                         |                        |                   | 1 20.        | AUTOPSY !                   |
|                                     | 0                                         |               |                                |              |                         |                        |                   |              |                             |
| 2I. ACCIDEN                         | NT (Specify)                              | PI.A          | CE (Home, farm, facto          | ww. street l | (CITY OR TO             | WNI                    | (COUNTY)          | (STATE)      | es No No                    |
| SUICIDE                             | (-2-00-3)                                 | OF<br>INJU    | office bldg., etc.)            | ly, street,  | (0111 01 10             | 17 217                 | (COCMII)          | (521222)     |                             |
| TIME (Mc                            |                                           |               | INJURY OCCURED                 |              | HOW DID INJU            | DV OCCUP?              |                   |              |                             |
| OF<br>INJURY                        | (203) (202)                               |               | While at Not W                 | hile         | HOW DID INJU.           | KI OCCUR?              |                   |              |                             |
|                                     |                                           | m.            | Work   At W                    | 100          |                         | _ ^ _                  |                   |              |                             |
| 22. I hereb                         | y certify that I a                        | ttended th    | ne deceased from               | my           | ,19.55, to              | Mental, 1              | 955., that I      | last saw t   | he deceased                 |
| alive of                            | 17 Sept. 195                              | and and       | that death occurre             | d at 9:      | 40 P.M fre              | m the cause            | e and on the      | date stated  | ahove.                      |
| SIGNAT                              | URE                                       | ,             | (Degree or title)              | at at        | A.W. C. A.V, 110        | DDRESS                 | Sangon the        | DATE SI      | GNED                        |
| las                                 | FF I WHO                                  |               | mil. L                         | heat K       | J. of ED Paral          | Sake                   | will a had        | 1750         | 1 1055                      |
| 23. BURIAL,                         |                                           | TE THERE      | OF NAME OF                     | CEMETERY     | J. Leloland OR CREMATOR | Y LOCATI               | ON (City, town    | , or county) | (State)                     |
| REMOVA                              | Trial 9                                   | /20/55        | Lo                             | udon Pa      | rk Cem.                 | Balt                   | o. Md.            |              |                             |
|                                     | C'D BY LOCAL RI                           |               | SIGNATURE                      |              | FUNERAL DIR             |                        | 1 1               | ADD          | RESS                        |
| REGISTRA                            | AR JE                                     | tu)           | bolia                          |              | INM U.                  | linkon                 | er y sa           | 110-12a      | lto 17                      |
|                                     |                                           |               | nun                            |              | XIIIIIII                | 7001011                | , , ,             | 1            | Ma P                        |
|                                     |                                           |               | 2, ,                           |              | V                       |                        |                   | /            | ma.                         |



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Supply every item of information carefully.

is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK.

correct age

DATE REC'D

LOCAL

### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 08570

| CERTIF | TACKA PINTS | OTA | TATA A | PETET          |
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| CERTIFICATE                                                                                                                                                   | E OF DEATH Reg. Dist.                            | No. 24                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------|
| 1. PLACE OF DEATH:                                                                                                                                            | 2. USUAL RESIDENCE (HOME) OF DECEASED            | *                                      |
| COUNTY CARROLL MARYLAND                                                                                                                                       | STATE Maryland COUNTY                            |                                        |
| CITY (If outside corporate limits, write RURAL) LENGTH OF STAY OR and give nearest town) (in this piace)                                                      | CITY(If outside corporate limits, write RURAL at | nd give nearest town)                  |
| X TOWN Rural - Sykesville 8 months                                                                                                                            | TOWN Baltimore                                   | 3V01-4                                 |
| HOSPITAL OR ANSTITUTION OR                                                                                                                                    | STREET (If rural give iocation)                  |                                        |
| 15 STREET ADDRESS Springfield State Hospital                                                                                                                  | 542 Radnor Avenue                                | 4                                      |
| 3. NAME OF (First) (Middle) DECEASED:                                                                                                                         | (Last) 4. DATE (Month) (D                        | (Year)                                 |
| (Type or Print) RERTHA LOUISE R                                                                                                                               | RUSSELL DEATH: 9                                 | 19 19 55                               |
| RACE: WIDOWED, DIVORCED.                                                                                                                                      | OF BIRTH: 9. AGE iast birthday   F UNDER 1 YI    | EAR IF UNDER 24 HRS.  Bys Hours   Min. |
| F W (Specify): single 6/9/                                                                                                                                    | 74 81 yrs.                                       |                                        |
| IOA. USUAL OCCUPATION (Give kind of work done during most of working life, OR INDUSTRY:                                                                       | 11. BIRTHPLACE (State or foreign country): 12.   | CITIZEN OF WHAT                        |
| even if retired): teacher   education                                                                                                                         |                                                  | USA                                    |
| 13. FATHER'S NAME:                                                                                                                                            | 14. MOTHER'S MAIDEN NAME:                        |                                        |
| Marcus Russell                                                                                                                                                | Helen Spoor                                      |                                        |
| 15. WAR DECEASED EVER IN U.S. ARMED FORCES: (Yes, no, or unk.) (If Yes, give war or dates                                                                     | 17. INFORMANT & ADDRESS:                         |                                        |
| of service)                                                                                                                                                   | Record, Springfield State Hos                    | pital                                  |
| 18. MEDICAL CERTIFICAT I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                     | ION                                              | INTERVAL BETWEEN                       |
| 11.1.4.X                                                                                                                                                      |                                                  |                                        |
| IMMEDIATE CAUSE (A) Bronchopner                                                                                                                               | ımonia                                           | 3 days                                 |
| ANTECEDENT CAUSE (S)                                                                                                                                          |                                                  |                                        |
|                                                                                                                                                               | alvulitis, inactive, with                        | years                                  |
| STATING UNDERLYING CAUSE LAST.                                                                                                                                | of mitral valve                                  |                                        |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING Chronic                                                                                                          | Brain Sundrome associated with                   |                                        |
| TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Senile bra n                                                                          | disease. with psychotic reaction                 | n l year                               |
| 194. DATE OF OPERATION:   198. MAJOR FINDINGS OF OPERATION                                                                                                    |                                                  | 20. AUTOPSY?                           |
|                                                                                                                                                               |                                                  | YES NO                                 |
| 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER) |                                                  | y) (State)                             |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While While at work at work                                                                         | 21F. HOW DID INJURY OCCUR?                       |                                        |
| 22. I hereby certify that I attended the deceased from 9/1 alive on 9/18, 1955, and that death occurred at                                                    | 2:30 AM, from the causes and on the date s       | stated above.                          |
| LIATTER H. MINIEMANIA                                                                                                                                         | ADDRESS DAT<br>D. Sykesville, Maryland 9/        | 1945                                   |
| 23. BURIAL, CREMATION. DATE THEREOF / NAME OF CEMETE                                                                                                          | ERY OR CREMATORY   LOCATION (City, town, or      | county) (State)                        |
| PREMOVAL (SPECIFY) CONT 21 1955 GOVENS Pro                                                                                                                    | to Baltina                                       | M.                                     |

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STREET

LENGTH OF STAY

(in this place)

(Day)

(Year)

Hours | 12. CITIZEN OF WHAT COUNTRY

> INTERVAL BETWEEN ONSET AND DEATH

AUTOPSY?

(State)

I last saw the deceased date stated above. DATE SIGNED

CITY(If outside corporate limits, write RURAL and give nearest town)

(If rural give location)

2. USUAL RESIDENCE (HOME) OF DECEASED:

Baltimore Cata

2339 Woodridge Ave.

4. DATE (Month)

DEATH: Spt.

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|-----------------------------|------------------------------------------------------------------------|--------------------------------------------------------------------------------|
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| 0                           | of                                                                     | 4+0                                                                            |
|                             | item                                                                   | 06 20                                                                          |
| TG.                         | every                                                                  | 000000                                                                         |
| INDIN                       | upply                                                                  | o tho                                                                          |
| OR B                        | NK. S                                                                  | - seemily                                                                      |
| MARGIN RESERVED FOR BINDING | IITE PLAINLY, WITH UNFADING INK. Supply every item of information care | marially immented Dhunisians whose weith the consess of death showing and love |
| RES                         | UNE                                                                    |                                                                                |
| RGIN                        | WITH                                                                   | + Dh.                                                                          |
| MA                          | AINIX,                                                                 | imanonton                                                                      |
| I)                          | PL                                                                     | 11                                                                             |
| I)                          | ILE                                                                    | 0.00                                                                           |

SE PLEA

REGISTRAR

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1. PLACE OF DEATH:

CITY (If outside corporate limits, write RURAL)

(First)

Lee

and give nearest town)

HOSPITAL OR

INSTITUTION OR STREET ADDRESS

COUNTY

NAME OF

DECEASED:

(Type or Print)

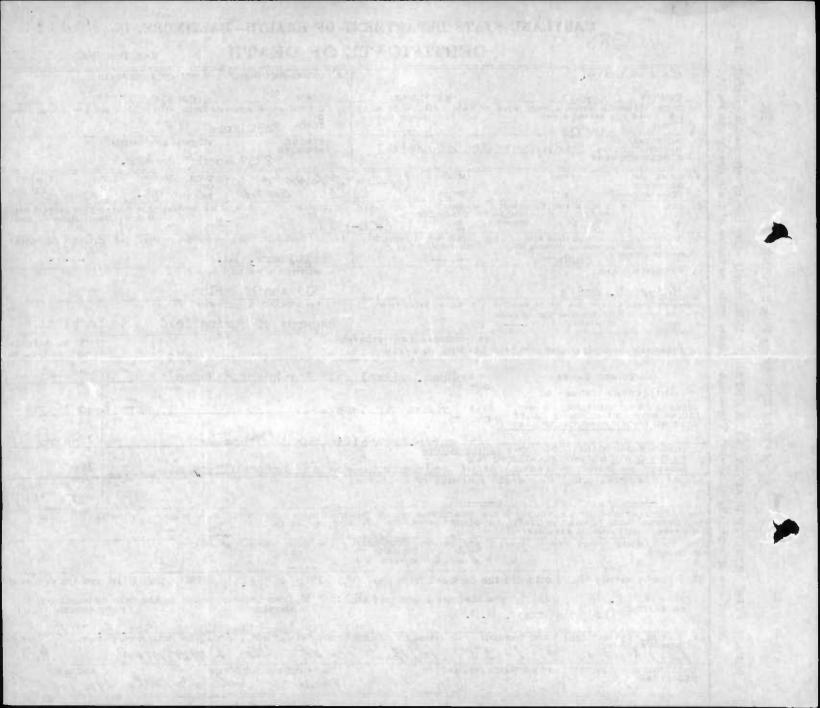
TOWN

| y item           | RACE: WIDOWED, DIVORCED.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | -1920   35 yrs.                             | Days Hours  |  |  |  |  |
|------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|-------------|--|--|--|--|
| y every          | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):  barber  10B. KIND OF BUSINESS OR INDUSTRY:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Baltimore, Md.                              | CITIZEN OF  |  |  |  |  |
| Supply<br>te the | 13. FATHER'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 14. MOTHER'S MAIDEN NAME:                   |             |  |  |  |  |
| Su               | Robert E. Smith Elizabeth Furlong                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                             |             |  |  |  |  |
|                  | (Yes, no, or unk.) (If Yes, give war or dates                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 17. INFORMANT & ADDRESS:                    |             |  |  |  |  |
| l-e              | no of service) ?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Records of Springfield State                | Hospital    |  |  |  |  |
|                  | 18. MEDICAL CERTIFICAT                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | TION                                        | INTERVAL BE |  |  |  |  |
| TH UNFADING      | 4/0 X IMMEDIATE CAUSE  ANTECEDENT CAUSE (S)  (A)Chron. mitral DUE TO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | valvular heart disease                      | 15 yrs      |  |  |  |  |
| WITH U           | DISEASES OR CONDITIONS, IF ANY. GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  DUE TO  Theumatic fever more that the condition of the condition |                                             |             |  |  |  |  |
| M t              | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                             |             |  |  |  |  |
| AINLY, W         | TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                             |             |  |  |  |  |
| 1 3              | 19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | N                                           | 20. AUTO    |  |  |  |  |
| 6                | 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, factory. OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., etc. (Statistical Examiner) (County) (Statistical Examiner)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                             |             |  |  |  |  |
| WRITE            | 21b. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED 21F. HOW DID INJURY OCCUR?  While Not while at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                             |             |  |  |  |  |
| 0                | 22. I hereby certify that I attended the deceased from May 28., 1952, to Spt. 4., 1955, that I last saw the dec                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                             |             |  |  |  |  |
| TYPE             | alive on Spt. 4 , 1955 , and that death occurred at 1.50 AM, from the causes and on the date stated above SIGNATURE Martin Gross, M.D. DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                             |             |  |  |  |  |
| SE TY            | 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMET                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ERY OR CREMATORY   LOCATION (City, town, of | 5 1955      |  |  |  |  |

Springfield State Hospital

(Middle)

Edward



## 8569

#### CERTIFICATE OF DEATH

Reg. Dist. No.....

21. ACCIDENT SUICIDE

HOMICIDE

2. USUAL RESIDENCE (HOME) OF DECEASED. 1. PLACE OF DEATH-COUNTY Maryland MARYLAND CITY (If outside corporate limits, write RURAL and LENGTH OF STAY CITY (If outside corporate limits, write RURAL and give nearest town) Town Rural, Nr. Taneytown (in this place) Rural. Nr. Taneytown TOWN STREET Mailing Active Sive location) Mailing Address INSTITUTION OR STREET ADDRESS Littlestown, Pa. R.D.1. Carrol ADDRESS Littlestown. Pa. R.D.1 Carroll Co. (Middle) (Year) (Last) (Month) (Day) Sell H. DEATH 19 7. SINGLE, MARRIED 8. DATE OF BIRTH 9. AGE last birthday | If under. 1 year | If under 24 hrs. | Months. | Days | Hours | Min. WIDOWED, DIVORCED (Specify) Married 7/28/1897 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? Frederick Co., Md. Grocery Store Emma Jane Michael Jacob F. Sell R.D.1. Carroll Co. 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. INFORMANT AND ADDRESS Littlestown, Pa. 212-03-0507

18. MEDICAL CERTIFICATION INTERVAL BETWEEN I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH ONSET AND DEATH Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause isst II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes |



INJURY Work At work 22. I hereby certify that I attended the deceased from..

INJURY

While at

(Specify)

TIME (Month) (Day) (Year) (Hour)

au 7 1943 to Sept 2-19 J. that I last saw the deceased

and that death occurred at ... 2:45 .. P...m., from the causes and on the date stated above. alive on (Degree or title) SIGNATUR

23. BURIAL, CREMATION BREMOVAL (Specify) Reformed Cemetery

REGISTRAR'S SIGNATURE

NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county)

HOW DID INJURY OCCUR?

Taneytown, Carroll Co., Md.

(COUNTY)

PLACE (Home, farm, factory, street, OF office bidg., etc.)

INJURY OCCURRED

Not While

ADDRESS Littlestown.

No 🗆

(STATE)

(CITY OR TOWN)

MARGIN RESERVED FOR BINDING

BUREAU V. S.

5361 61 das

BECEINEU

| MARYLAND | STATE | DEPARTMENT | OF | HEALTH—BALTIMORE, | 18 | 08573 |
|----------|-------|------------|----|-------------------|----|-------|
|----------|-------|------------|----|-------------------|----|-------|

OETO CERTIFICATE OF DEATH

g. Dist. No. 74

| 8510                                                                                                                                                                 | Reg. Dist.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 110/             |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|
| I. PLACE OF DEATH:                                                                                                                                                   | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                  |
| COUNTY Carroll MARYLAND                                                                                                                                              | STATE Md. COUN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | TY               |
| CITY (If outside corporate limits, write RURAL CINCTH OF STOR and give nearest town)  TOWN Henryton LI Days                                                          | CITY (If outside corporate limits, write RURAL RE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 3 VOI-4          |
| HOSPITAL OR INSTITUTION OR 3 STREET ADDRESS Henryton, Maryland                                                                                                       | STREET (If rural give location) ADDRESS 1102 Edmondson Avenue                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | /                |
| 3. NAME OF (First) (Middle) DECEASED: (Type or Print) Henry W.                                                                                                       | (Last) 4. DATE (Month) (Day OF DEATH: 9- 27                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                  |
| 5. SEX: 6. COLOR OR RACE: WIDOWED, DIVORCED, (Specify): Married 8. DA                                                                                                | TE OF BIRTH: 9. AGE last birthday: IF UNDER 1 YI 1-27-1891 64 yrs. Months De                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ys Hours Min.    |
| ios. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Unknown                                                                  | Frederick Co., Md.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | COUNTRY? U. S.   |
| 13. FATHER'S NAME:                                                                                                                                                   | 14. MOTHER'S MAIDEN NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                  |
| William Sewell                                                                                                                                                       | Willetta Fry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                  |
| 15 WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY No.:                                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                            | Henry W. Sewell - 1102 Edm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ondson Ave.      |
| 18. MEDICAL CERTIFIC                                                                                                                                                 | CATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Interval Between |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.  (c)  DUE TO  (b) Cardiac insuf  DUE TO  (c) | ficiency                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                  |
| Conditions contributing to the death but not related to the disease or condition causing death.                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                  |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATI                                                                                                               | ON                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 20. AUTOPSY ?    |
| 21. ACCIDENT (Specify) PLACE (Home, farm, factory, structure of office bldg., etc.)                                                                                  | treet, (CITY OR TOWN) (COUNTY) (S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Yes No No STATE) |
| HOMICIDE   INJURY  TIME (Month) (Day) (Year) (Hour)   INJURY OCCURED   While at Not While INJURY   Not Work   At Work                                                | HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                  |
| 22. I hereby certify that I attended the deceased from9-                                                                                                             | 16,1955., to 9-27, 1955, that I last to: 40 A.M., from the causes and on the date ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | stated above.    |
| REMOVAL (Specify)                                                                                                                                                    | Henryton, Maryland ETERY OR CREMATORY LOCATION (City, town, or comparing the comparing |                  |

VS. A15

BUREAU V. S. BUREAU V. S.

BUREAU V. S.

\* \* \* \* \* \* \* \*

SEP 19 1955

BECEINED

MARGIN RESERVED FOR BINDING

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08575 CERTIFICATE OF DEATH Reg. Dist. No. 74 8572

| Reg.   | Dist. | No.  | 74 |
|--------|-------|------|----|
| wee P. | Dist. | 110. | /  |

| I. PLACE OF DEATH:                                                                                                                | 2. USUAL RESIDE                       | NCE (HOME) OF DECEASE           | D:                    |
|-----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------|---------------------------------|-----------------------|
| COUNTY Carroll MARYLAND                                                                                                           | crare Massell                         | and county Fre                  | domi als              |
| COUNTY Carroll MARYLAND CITY (If outside corporate limits, write RURAL) LENGTH OF STAY                                            | CITY(If outside of                    | corporate limits, write RURAL   | nd give nearest town) |
| OR and give nearest town) (in this place)                                                                                         | OR                                    |                                 | 4 = 14                |
| Sykesville 2month 27days                                                                                                          | STREET                                | rersville                       | 10x-2                 |
| . INSTITUTION OR                                                                                                                  | ADDRESS                               | (If rural give location)        | /                     |
| /5 STREET ADDRESS Springfield State Hospital                                                                                      |                                       |                                 | <b>V</b>              |
| 3. NAME OF (First) (Middle) (DECEASED:                                                                                            | (Last)                                |                                 | Day) (Year)           |
| (Type or Print) CHARLES WILLIAM S                                                                                                 | SMITH                                 | OF DEATH: Sept.                 | 27 1955               |
| 5. SEX:   6. COLOR OR 7. SINGLE, MARRIED,   8. DATE   RACE: WIDOWED, DIVORCED,                                                    | OF BIRTH: 9                           | . AGE last birthday IF UNDER 1  | TEAR IF UNDER 24 HRB. |
| Male White (Specify): Widowed 2-21                                                                                                | 1-82                                  | 73 My yrs. Months I             | Days Hours Mln.       |
| 10A. USUAL OCCUPATION (Give kind of tob. KIND OF BUSINESS work done during most of working life. OR INDUSTRY:                     |                                       | State or foreign country):  12. | CITIZEN OF WHAT       |
| even if retired): Cattle Dealer                                                                                                   | Maryland                              |                                 | U.S.A.                |
| 13. FATHER'S NAME:                                                                                                                | 14. MOTHER'S MA                       | IDEN NAME:                      |                       |
| James W. Smith                                                                                                                    | 71 11                                 | 4                               |                       |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCEST   16. SOCIAL SECURITY NO.                                                             | 17. INFORMANT &                       | ADDRESS:                        |                       |
| (Yes, no, or unk.) (If Yes, give war or dates                                                                                     |                                       |                                 |                       |
| NO of service) ~   AMAC >                                                                                                         | Hospital                              | records                         |                       |
| 18. MEDICAL CERTIFICAT. I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                        | ION                                   |                                 | INTERVAL BETWEEN      |
| 151X                                                                                                                              |                                       |                                 | ONSET AND DEATH       |
| IMMEDIATE CAUSE (A) Carcinoma o                                                                                                   | f the stomach                         | with metastasis :               | into                  |
| ANTECEDENT CAUSE (S:                                                                                                              |                                       |                                 |                       |
| DISEASES OR CONDITIONS, IF ANY, (B) PANCIOLES and                                                                                 | transverse c                          | ดโดท                            | months                |
| GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                                                     | C C C C C C C C C C C C C C C C C C C | 92011                           | 3110110110            |
| (6)                                                                                                                               |                                       |                                 |                       |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING CBS assortion the Death But Not Related to the                                       |                                       | and Talbanata                   |                       |
| TO THE DEATH BUT NOT RELATED TO THE DOS ASSOCIATION CAUSING DEATH. CISCASE WITT                                                   | nevelotio re                          | senile brain                    | Unknown               |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION                                                                          |                                       | acoron.                         |                       |
|                                                                                                                                   |                                       |                                 | 20. AUTOPSY?          |
|                                                                                                                                   |                                       |                                 |                       |
| 21A. ACCIDENT WAS UNDERLYING ☐ 21B. PLACE (Home, farm, fact OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER. NOTIFY MEDICAL EXAMINER) | etc. 21c. WHERE D                     | ID (City or town) (Coun         | ty) (State)           |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work at work                                 | 21F. HOW DID IN                       | NJURY OCCUR?                    |                       |
| 22. I hereby certify that I attended the deceased from 6-30                                                                       | ), 19.55, to .9-                      | -27, 1955, that I last          | saw the deceased      |
| alive on 9-27, 1955, and that death occurred at                                                                                   |                                       |                                 |                       |
| (\$IGNATURE                                                                                                                       | ADDRESS                               | DA                              | re signed             |
| Marther SI. Johnson telah.                                                                                                        | . D. Springfield                      | d State Hosp. //                | - 27-55               |
| 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETE                                                                                | . / . /                               | LOCATION (City, town, or        | county) (State        |
| Cremation Out 3, 1755 Tort Luc                                                                                                    | lun Ceroto                            | Vashingter                      | DC.                   |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE                                                                                         | 24. FUNERAL OF                        | RECTOR                          | ADDRESS               |

The Transport of the Company of the

ACTOR SECTION OF THE PROPERTY OF THE PARTY.

BUREAU V. E.

961 g 1955

#### MARYLAND STATE DEPARTMENT OF HEALTH

#### 2411 N. Charles Street, Baltimore

## 8573

## CERTIFICATE OF DEATH

Reg. Dist. No.

|                                                         |                                                                                 |                                         |                                 |                                      | eg. Dist. Ive | <b>9</b> *                                         |
|---------------------------------------------------------|---------------------------------------------------------------------------------|-----------------------------------------|---------------------------------|--------------------------------------|---------------|----------------------------------------------------|
| 1. PLACE OF DEAT<br>COUNTY                              |                                                                                 |                                         | 2. USUAL RESIDENCE (I           | HOME) OF DEC                         |               | Y                                                  |
|                                                         | Carroll                                                                         | MARYLAND                                | Maryla                          |                                      | Carrol.       | 1                                                  |
|                                                         | corporate limits, write RUR                                                     | AL and   LENGTH OF STAY (in this place) | OR CITY (If outside corpor      |                                      | URAL and giv  | ve nearest town)                                   |
| X TOWN                                                  | Mt. Airy                                                                        | (in this place)                         | TOWN Mt                         |                                      |               | X                                                  |
| HOSPITAL OR INSTITUTION OF STREET ADDRESS               |                                                                                 |                                         | STREET<br>ADDRESS               | (If rural, g                         | ive location) |                                                    |
| 3. NAME OF                                              | (First)                                                                         | (Middle)                                | (Last)                          | 4. DATE                              | (Month)       | (Day) (Year)                                       |
| (Type or Print)                                         | CHARLES                                                                         | W. SPE                                  | NCER                            | OF<br>DEATH                          | Sepx          | 13 1953                                            |
| 5. SEX                                                  | 6. COLOR OR RACE                                                                | 7. SINGLE, MARRIED.                     | 8. DATE OF BIRTH                | 9. AGE last birth                    |               | 1 year   If under 24 br                            |
| male                                                    | white                                                                           | WIDOWED DIVORCED,<br>(Specifyllarried   | 4-22-1876                       | 79                                   | yrs. Months   | Days Hours Min.                                    |
| 10a. USUAL OCCUP                                        | PATION (Give kind of work working life, even if retired)  Tetlred               | Bethiem Steel                           | II. BIRTHPLACE (State of Maryla |                                      | 12            | COUNTRYS                                           |
| 13. FATHER'S NAM                                        | ME                                                                              | · · · · · · · · · · · · · · · · · · ·   | 14. MOTHER'S MAIDEN             |                                      |               |                                                    |
|                                                         | David St                                                                        | encer                                   | Elizabeth                       | Harris                               |               |                                                    |
| 15. WAS DECRASED I                                      | FURR IN ITS ARMED FORCES                                                        | 2 1 16 SOCIAL SECURITY NO               |                                 | ADDRESS                              |               |                                                    |
| (Yes no or unknown)                                     | ) (If yes, give war or dates iservice)                                          | 01 219-05-2272                          | Mrs. Margare                    | t Spence                             | r. Sa         | me                                                 |
|                                                         |                                                                                 | 18. MEDICAL CE                          |                                 |                                      |               |                                                    |
| Immedia Antecede Disease or giving rise                 | te cause (a)                                                                    |                                         | Failer                          | thus                                 |               | INTERVAL BETWEEN ONSET AND DEATH Soulder           |
| II. OTHER SIGNIF Conditions contrib related to the dise | (c) FICANT CONDITIONS outling to the death but not ase or condition causing dea | th.<br>FINDINGS OF OPERATION            |                                 |                                      |               | 20. AUTOPSY?                                       |
| A COLDENIA                                              | (Specify)   PLA                                                                 | CE (Home, farm, factory, street,        | : (CITY OR )                    | POWNI                                | (COUNTY)      | Yes No (STATE)                                     |
| 21. ACCIDENT SUICIDE HOMICIDE TIME (Month) OF           | OF INJ (Day) (Year) (Hour)                                                      | office bldg., etc.)                     | HOW DID INJURY OC               |                                      | (0001(11)     | (SIAIL)                                            |
| alive on S. SIGNATURIV  23. BURIAL, CREATE BURIAL TSP   | MATION   DATE THERE CITY)   9-16-19                                             | e deceased from                         | SUX Ciry<br>ORY OR ORDMATORY    | causes and on LOCATION (City Carroll | the date st   | Ated above.  DATE SIGNED  9//3/54  (State)  ryland |
| DATE REC'D BY                                           | 1955 Covert                                                                     | R. Dewith                               | C. M. Waltz                     |                                      | eld,Md        | ADDRESS                                            |

The correct age d

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

BUREAU V. S.

SECEINED SECEINED

please write the causes of death clearly and legibly.

correct age is especially important. Physicians:

PLEASE TYPE OR WRITE

| MARYLAND STATE DEPARTMEN                                                                                                                                      | T OF HEALTH—BALTIMORE, 18                       | 08577            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|------------------|
| 8574 - CERTIFICATE                                                                                                                                            |                                                 | . No. 2H         |
| 1. PLACE OF DEATH:                                                                                                                                            | 2. USUAL RESIDENCE (HOME) OF DECEASE            | D:               |
| Annall                                                                                                                                                        | Marriand Mort                                   |                  |
| CITY (If outside corporate limits, write RURAL) LENGTH OF STAY                                                                                                | CITYIIf outside corporate limits, write RURAL   |                  |
| OR and give nearest town)  X TOWN Rural - Sykesville 38Y 8M 18 D                                                                                              | OR TOWN Gaithersburg                            | 15 1 2           |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State Hospital                                                                                          | STREET (If rural give location)                 | 131-23           |
|                                                                                                                                                               | 0.5                                             | Day) (Year)      |
| (Type or Print) Mertie Estelle                                                                                                                                | STARNER OF DEATH: 90                            | 1955             |
| 5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single 7/3/                                                                             | Months I                                        |                  |
| IOA. USUAL OCCUPATION (Give kind of 10B. KIND OF BUSINESS                                                                                                     | 11. BIRTHPLACE (State or foreign country):  12. | CITIZEN OF WHAT  |
| work done during most of working life, even if retired): none                                                                                                 | Montgomery Co., Md.                             | USA USA          |
| 13. FATHER'S NAME:                                                                                                                                            | 14. MOTHER'S MAIDEN NAME:                       |                  |
| CHarles C. Starner                                                                                                                                            | Bertie Baldwin                                  |                  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCEST   16. SOCIAL SECURITY NO.                                                                                         | 17. INFORMANT & ADDRESS:                        |                  |
| (Yes, no, or wik.) (If Yes, give war or dates of service) none                                                                                                | Record, Springfield State                       | Hospital         |
| 18. MEDICAL CERTIFICAT                                                                                                                                        | ION                                             | INTERVAL BETWEEN |
| 1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                            |                                                 | ONSET AND DEATH  |
| 572.2 IMMEDIATE CAUSE (A) Septicemia                                                                                                                          |                                                 | 36 hours         |
| ANTECEDENT CAUSE (S)                                                                                                                                          |                                                 |                  |
| DISEASES OR CONDITIONS, IF ANY.  GIVING RISE TO THE ABOVE CAUSE  DISEASES OR CONDITIONS, IF ANY.  (B) Ulcerative                                              | colitis                                         | unknown          |
| STATING UNDERLYING CAUSE LAST.  (C)                                                                                                                           |                                                 |                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING                                                                                                                  |                                                 |                  |
| TO THE DEATH BUT NOT RELATED TO THE Schizophrenic                                                                                                             |                                                 | type 40 yrs.     |
| 19a. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION                                                                                                      |                                                 | 20. AUTOPSY?     |
|                                                                                                                                                               |                                                 | YES NO           |
| 21A. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fact OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bldg., (IF EITHER, NOTIFY MEDICAL EXAMINER) | etc. INJURY OCCUR?                              | ty) (State)      |
| 21D. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While 1 work at work                                                                                | 21F. HOW DID INJURY OCCUR?                      |                  |
| 22. I hereby certify that I attended the deceased from 9/6                                                                                                    | , 1955, ten 9/8 , 1955, that I last             | saw the deceased |
| alive on 9/7, 1955, and that death occurred at                                                                                                                | 2:50Am, from the causes and on the date         |                  |
| Walter of Journaly M                                                                                                                                          | . D. Spkesville, Maryland 9                     | /8/55            |
|                                                                                                                                                               | ERY OR CREMATORY LOCATION (City, town, or       |                  |
| DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE                                                                                                                   | 24 JUNERAL DIRECTOR                             | ADDRESS          |
| Sell. 9, 1955 C. Harry Ween                                                                                                                                   | Um ( sok pic. 12/7 &                            | + Bull.          |

A15-10-53 VS.

BUREAU V. S.

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#### MARYLAND STATE DEPARTMENT OF HEALTH

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

## CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 80

| FOR MEDICAL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | EXAMINERS Res                                        | . Dist. No.                                                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|---------------------------------------------------------------------|
| I. PLACE OF DEATH- COUNTY CARROLL MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | rung and                                             | COUNTY                                                              |
| CITY (If outside corporate limits, write RURAL and CITY (If outside corporate limits) ( | CITY (If outside corporate limits, write RUI OR TOWN | son x                                                               |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS SEW Which sor                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS (If rural, give                       | location)                                                           |
| 3. NAME OF (First) (Middle) DECEASED (Type or Print) JESSE THOMAS S7                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Last) 6. DATE (I) OF DEATH                          | Month) (Day) (Year)                                                 |
| 5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 8. DATE OF BIRTH 9. AGE last birthda                 | y If under I year   If under 24 hrs.   Months   Days   Hours   Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  10b. Kind of Business or Industry                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 11. BIRTHPLACE (State or foreign country)            | 12. CITIZEN OF WHAT COUNTRY?                                        |
| 13. FATHER'S NAME                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 14. MOTHER'S MAIDEN NAME                             | t                                                                   |
| 15. WAS DECRASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO. (Yes. no, or unknown)   (If yes. give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (Orether Stevenson)                                  | Lew Kabenden 14                                                     |
| 18. MEDICAL CE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | RTIFICATION                                          | INTERVAL BETWEEN                                                    |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                      | ONSET AND DEATH                                                     |
| Immediate cause (a) (Tleri) sele                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | The C. V Macaa                                       | a gum t                                                             |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                      |                                                                     |
| II. OTHER SIGNIFICANT CONDITIONS  Conditions contributing to the death but not related to the disease or condition causing death.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                      |                                                                     |
| 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                      | 20. AUTOPSY?                                                        |
| 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING OF office bldg., etc.)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (CITY OR TOWN)                                       | (COUNTY) (STATE)                                                    |
| PRIMARY OR CONTRIBUTING OF office bldg., etc.) CAUSE OF DEATH.  TIME (Month) (Day) (Year) (Hour) INJURY OCCURRED OF While at Not while INJURY m. work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | HOW DID INJURY OCCUR?                                |                                                                     |
| 22. I certify that I took charge of the remains described above, held an A obtained by said Autopsy, Inspection or Inquiry, find that said decerom: natural causes A accident, suicide, homicide, SIGNATURE (Degree or title)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ased died on the day stated above, and deat          | h in my opinion resulted  DATE SIGNED  Poly 27/55                   |

VS. A15A

BUREAU V. S.

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#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

| TINTAL T SULTE. | DELLE DELLE | TA OI MANAGEMENT DIESE | 22(2 0 2 4 2 2 | , 10  |    |    |
|-----------------|-------------|------------------------|----------------|-------|----|----|
| MEDICAL         | EXAMINER'S  | CERTIFICATE            | OF             | DEATH | No | 74 |

| -        | t                              | MARYLAND STATE DEPARTMENT OF I                                                                                                          | HEALTH—BALTIMORE, 18                                                         | Reg. Dist.                                |
|----------|--------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|-------------------------------------------|
|          | correct                        | MEDICAL EXAMINER'S CER'                                                                                                                 | TIFICATE OF DEATH                                                            | No. 74                                    |
|          |                                | 1. PLACE OF DEATH:                                                                                                                      | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                       |                                           |
|          | The ly.                        | COUNTY Sykesville Carroll MARYLAND                                                                                                      | STATE Maryland county Montgome:                                              | ry                                        |
|          | carefully. To and legibly.     | CITY (If outside corporate limits, write RURAL OR and give nearest town) ville 3 months                                                 | CITY (If outside corporate limits write RURAL and OR TOWN Germantown         | give nearest town)                        |
|          | -                              | HOSPITAL OR INSTITUTION OR STREET ADDRESS Springfield State HOspital                                                                    | STREET (If rural, give location) ADDRESS                                     | V                                         |
| -        | tion                           | 3. NAME OF (First) (Middle)                                                                                                             | (Last) 4. DATE (Month) (Day)                                                 | ) (Year)                                  |
| 1        | cle                            | DECEASED: (Type or Print) Cora                                                                                                          | Thompson DEATH 9 30                                                          | 19 55                                     |
| 1        | f information<br>death clearly |                                                                                                                                         | OF BIRTH: 9. AGE last birthday: IF UNDER 1 Y  1/16/75 80 yrs. Months Da      |                                           |
| 16       | of of                          | 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Houseiwfe                                     |                                                                              | CITIZEN OF WHAT COUNTRY?                  |
|          | item<br>ses o                  | 13. FATHER'S NAME:                                                                                                                      | 14. MOTHER'S MAIDEN NAME:                                                    | USA                                       |
| BINDIN   | every iten<br>he causes        | Addison Dodd                                                                                                                            | Jane Thompson                                                                |                                           |
|          | eve<br>he                      | 15. WAS DECEASED EVER IN U.S. ARMED FORCES ? 16 SOCIAL SECURITY NO .                                                                    | 17. INFORMANT & ADDRESS:                                                     |                                           |
| FOR      | D +3                           | (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                               | Record, Springfield State Hospi                                              | fe+                                       |
|          | Suppl                          | 18. MEDICA                                                                                                                              | AL CERTIFICATION                                                             | 1                                         |
| RESERVED | please w                       | I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:  Immediate cause (a) Printer Au                                                    | y edeca a                                                                    | INTERVAL BETWEEN ONSET AND DEATH MULLILLY |
| RES      | NG I                           | Antecedent cause(s)  DUE TO  DS phy 1 as                                                                                                | tien                                                                         | muntes                                    |
| MARGIN   | UNFADING<br>Physicians: p      | Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)                                        | of curdled mulk                                                              |                                           |
| AR       | Phy                            | IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING Chronic b                                                                                  | rain syndrome associated with ser                                            | of le                                     |
| Z        |                                | DISEASE OR CONDITION CAUSING DEATHbrain dise                                                                                            | ase, with psychotic reaction                                                 | 7 - 10 yrs                                |
|          | Y, WITH important.             | 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                                                |                                                                              | 20. AUTOPSY? Yell No                      |
| 4        | Y,<br>mp                       | 21a. EXTERNAL CAUSE WAS PRIMARY   or CONTRIBUTING   21b. PLACE (Home, farm, factory, OF street, office bidg., etc., INJURY nursing home | (06)                                                                         | (State)                                   |
|          |                                | CAUSE OF DEATH. INJURY NUTSING home 21d. TIME (Month) (Day) (Year) (Hour)   21e. INJURY OCCURRED                                        | Montgomery County 21f. How DID INJURY OCCUR?                                 | Maryland                                  |
|          | AI                             | OF Not while at Not while injury 28 55 ? M. While at work                                                                               | Fall - history indefinite                                                    |                                           |
|          | PLAIN<br>pecially              | 22. I hereby certify that I took charge of the remains describ                                                                          |                                                                              | , Inquiry [], and                         |
|          | LE<br>es                       | find that death resulted from: Natural causes [], Accid                                                                                 | dent [], Suicide [], Homicide [], Undeter                                    | mined cause [].                           |
|          | RI is                          | SIGNATURE 1 7/6                                                                                                                         | CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. | 9/30/55                                   |
| 52       | ₩ 90 ×                         | 23. BURIAL, CREMATION,   DATE THEREOF   NAME OF CEMETER                                                                                 |                                                                              | ., - , - , - , - , - , - , - , - , - , -  |
| 70       | 3                              | REMOVAL (Specify): D.T 2 1900 b 0 . 10                                                                                                  | Cent heelewills                                                              | 1 / 1                                     |
| 5A       | PLEA                           | DATE REC'D BY LOCAL   REGISTRAR'S SIGNATURE                                                                                             | 24 FUNERAL DIRECTOR                                                          | ADDRESS                                   |
| A15A     | Id (                           | Sept. 301955 C. Herry Will                                                                                                              | Koy W Barber Laylons                                                         | elle had                                  |
| vi       |                                |                                                                                                                                         | Bus Family 91 Backs                                                          |                                           |

BUREAU V. E.

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|    | MARYLAND | STATE | DEPARTMENT | OF | HEALTH—BALTIMORE, | 18 | 0.0 |
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| and the same of the same of |                      | 080            |
|-----------------------------|----------------------|----------------|
| 8577                        | CERTIFICATE OF DEATH | Reg. Dist. No. |

| 5. SEX:   6. COLOR OR   7. SINGLE, MARRIED,   8. DATE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | OR Beltimone -12                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| CITY (If outside corporate limits, write RURAL OR and give nearest town)  X TOWN Sykesville  HOSPITAL OR Grand View Mansion RISTITUTION OR STREET ADDRESS Springfield Rd. Rt. 32  3. NAME OF Grist (Middle)  DECEASED: (Type or Print)  5. SEX: 6. COLOR OR 7. SINGLE, MARRIED, WIDOWED, DIVORCED, RACE: (Specify): dowed Feb. 2  10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife  13. FATHER'S NAME:  15. WAR DECEASED EVER IN U.S. ARMED FORCES: (Yes, no, or unk.) (If Yes, give war or dates of service)  16. TOWN MARYLAND (In this place) (Middle)  17. SINGLE, MARRIED, S. DATE (Specify): dowed Feb. 2  18. SOCIAL SECURITY NO. (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | CITY(If outside corporate limits, write RURAL and give nearest town)  R Baltimore -12  STREET ADDRESS  5700 Loch Raven Blvd.  (Last)  PFER  A. DATE (Month) OF DEATH: Sept. 9.1955 19  OF BIRTH:  9. AGE last birthday Months  11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT Baltimore Md.  14. MOTHER'S MAIDEN NAME: Amanda Palmer  17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| CITY (If outside corporate limits, write RURAL of and give nearest town)  X TOWN Sykesville 6 Week  HOSPITAL OR INSTITUTION OR Grand View Mansion STREET ADDRESS Springfield Rd. Rt.32  3. NAME OF (First) (Middle)  DECEASED: (Type or Print) MARGARET TOE  5. SEX: 6. COLOR OR 7. SINGLE. MARRIED. (Specify) dowed  Female White (Specify) dowed  10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): Housewife  13. FATHER'S NAME:  ? Heinz  15. WAR DECEASED EVER IN U.S. ARMED FORCES! (Yes, no, or unk.) (If Yes, give war or dates of service)  10A. USUAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | CITY(If outside corporate limits, write RURAL and give nearest town)  R Baltimore -12  STREET ADDRESS  5700 Loch Raven Blvd.  (Last)  PFER  A. DATE (Month) OF DEATH: Sept. 9.1955 19  OF BIRTH:  9. AGE last birthday Months  11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT Baltimore Md.  14. MOTHER'S MAIDEN NAME: Amanda Palmer  17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| HOSPITAL OR INSTITUTION OR Grand View Mansion Rd. Rt.32  3. NAME OF DECEASED: (Middle) MARGARET TOE SEX: 6. COLOR OR RACE: (Specify) idowed Feb. 2  10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): Housewife Tousewife Touse | STREET ADDRESS (If rural give location)  5700 Loch Raven Blvd.  (Last)  OF DEATH: Sept. 9. 1955 19  OF BIRTH: 9. AGE last birthday IF UNDER 1 YEAR HOURS Min.  11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT Baltimore Md.  14. MOTHER'S MAIDEN NAME:  Amanda Palmer  17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| INSTITUTION OR Grand View Mansion  9 STREET ADDRESS Springfield Rd. Rt.32  3. NAME OF DECEASED: (First) (Middle) DECEASED: (Type or Print) MARGARET TOE  5. SEX: 6. COLOR OR RACE: WIDOWED, DIVORCED, Specify): dowed  10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE OR INDUSTRY:  10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE OR INDUSTRY:  10B. KIND OF BUSINESS OR INDUSTRY:  11S. WAS DECEASED EVER IN U.S. ARMED FORCEST (Yes, no, or unk.) (If Yes, give war or dates of service)  12D. MARGARET TOE  13D. MARGARET TOE  15D. WARRIED. (Middle)  16D. MARGARET TOE  16D. MARRIED. S. DATE  17D. MARRIED. S. DATE  18D. KIND OF BUSINESS OR INDUSTRY:  18D. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Clast   4. DATE (Month) (Day) (Year) OF ER   9. AGE last birthday   15 UNDER 1 YEAR   15 UNDER 24 HRS.   16 UNDER 24 HRS.   17 UNDER 24 HRS.   18 UNDER 24 HRS.   18 UNDER 24 HRS.   19 UNDER 24 HRS.   19 UNDER 24 HRS.   10 UNDER 24 HRS.   10 UNDER 24 HRS.   11 UNDER 24 HRS.   12 UNDER 24 HRS.   13 UNDER 24 HRS.   14 UNDER 24 HRS.   15 UNDER 24 HRS.   16 UNDER 24 HRS.   17 UNDER 24 HRS.   18 UNDER 25 UNDE |
| DECEASED: (Type or Print) MARGARET  5. SEX:   6. COLOR OR RACE: WIDOWED. DIVORCED. Feb. 2  10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE  13. FATHER'S NAME:  7 Heinz  15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  16. COLOR OR T. SINGLE. MARRIED. S. DATE WIDOWED. DIVORCED. Feb. 2  17. SINGLE. MARRIED. S. DATE WIDOWED. DIVORCED. Feb. 2  18. SOCIAL SECURITY NO. OF SERVICE)  19. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (Last)  PFER  4. DATE (Month) (Day) (Year)  OF DEATH: Sept. 9. 1955  OF BIRTH:  9. AGE last birthday IF UNDER 1 YEAR HOURS Min.  11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT Baltimore Md.  14. MOTHER'S MAIDEN NAME:  Amanda Palmer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 5. SEX:   6. COLOR OR   7. SINGLE. MARRIED.   8. DATE   6. MILTON   7. SINGLE. MARRIED.   8. DATE   6. COLOR OR   7. SINGLE. MARRIED.   8. DATE   6. COLOR OR   7. SINGLE. MARRIED.   8. DATE   7. SINGLE. MARRIED.   9. DATE   9. | OF BIRTH:  9. AGE last birthday   If UNDER 1 YEAR   If UNDER 24 Hrs.    9. 1872   83 Yrs yrs.   Months   Days   Hours   Min.    11. BIRTHPLACE (State or foreign country):   12. CITIZEN OF WHAT    Baltimore Md.   USA    14. MOTHER'S MAIDEN NAME:   Amanda Palmer    17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| female white (Specify): dowed Feb. 2  IOA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWITE  13. FATHER'S NAME:  ? Heinz  15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)  NOR INDUSTRY:  OR INDU | 9.1872 83 yrs yrs. Months Days Hours Min.  11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT Baltimore Md. USA  14. MOTHER'S MAIDEN NAME: Amanda Palmer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| work done during most of working life, even if retired): HOUSEWISE  13. FATHER'S NAME:  15. WAR DECEASED EVER IN U.S. ARMED FORCEST (Yes, no, or unk.) (If Yes, give war or dates of service)  16. SOCIAL SECURITY NO.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Baltimore Md. USA USA 14. Mother's Maiden Name: Amanda Palmer                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| 13. FATHER'S NAME:  ? Heinz  15. Was Deceased Ever in U.S. Armed Forces: (Yes, no, or unk.) (If Yes, give war or dates of service)  no                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 14. MOTHER'S MAIDEN NAME: Amanda Palmer  17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| (Yes, no, or unk.) (If Yes, give war or dates of service)  15. Social Security No.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| (Yes, no, or unk.) (If Yes, give war or dates no none                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 17. INFORMANT & ADDRESS:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| 1 Home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | MI. WMIS. F. FAUL DWYCI (daughter)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
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| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | INTERVAL BETWEEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
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| IMMEDIATE CAUSE (A) ANTOSIG                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10 he cardio va what devan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| DISEASES OR CONDITIONS, IF ANY. (B)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | nic mys cordits & hypertusing                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| (C)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATIO                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | N 20. AUTOPSY?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| 21a. ACCIDENT WAS UNDERLYING 21B. PLACE (Home, farm, fac                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | tory, 21c WHERE DID (City or town) (County) (State)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| (IF EITHER, NOTIFY MEDICAL EXAMINER)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | INJURY OCCURY                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| PID. TIME (Month) (Day) (Year) (Hour) 21E INJURY OCCURRED While Not while at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 21F, HOW DID INJURY OCCUR?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| 22. I hereby certify that I attended the deceased from                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | , 19, to, 19, that I last saw the deceased                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| alive on 1993, and that death occurred at                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | P. M ADDRESS DATE SIGNED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
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| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE REGISTRAR LAT. 10, 1955 L. HALLY ELLEN                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 24. FUNERAL DIRECTOR Moth and ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |

BECEINED

BUREAU V. S.

SEP 13 1955

#### CERTIFICATE OF DEATH

Reg. Dist. No. 75

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No                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | . /                              |
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USUAL RES      | SIDENCE (HOM)          | E) OF DECEAS     | ED:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                  |
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| If outside corporate limits, write RU and give nearest town) Rural, Westminster                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        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| Manchester D: Manchester D: ADDRESS Westminster, 1                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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                                                                                              | STREET<br>ADDRESS |                        | ster Dist        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| ED: (First) Print) Emma M:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (Middle)<br>issouri                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (Last)<br>Wentz   | 4. DATE<br>OF<br>DEATH | 0/20/55          | (Day)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | (Year)                           |
| S. COLOR OR 7. SINGLE, WIDOWE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ог віктн:<br>1871 |                        | birthday: if UNI | The state of the s | ir UNDER 24 HRS.<br>Hours   Min. |
| one during most of working life,<br>fetired ousework                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | b. KIND OF BUSINESS OF INDUSTRY: Own home                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Carro             | ACE (State or fo       | l.               | U.S                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | NTREE                            |
| R'S NAME:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              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                                                                                              |                   | MAIDEN NAME:           |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          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| s D. Leese                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    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| CEASED EVER IN U.S. ARMED FORCES? 16 unk.) (If Yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | None 17.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | E. Wentz          | R. D. 3,               | Westmins         | stan M                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | id.                              |
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| diate cause (a)  edent causes (s)  e or conditions, if any, rise to the above cause the underlying cause last.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | MEDICAL CERTIFICATI                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     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                                                                                                                                                                                                             | Interval Retwee                  |
| diate cause  edent causes (s)  or conditions, if any, rise to the above cause the underlying cause last.  SIGNIFICANT CONDITIONS ons contributing to the death but not                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | . MEDICAL CERTIFICATI EADING TO DEATH  CITTURE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                   | tieThea                |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | Interval Retwee                  |
| diate cause  dedent causes (s)  s or conditions, if any, rise to the above cause the underlying cause last.  SIGNIFICANT CONDITIONS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | EADING TO DEATH  COLUMN  CALLES OF THE STATE |                   | tie?fea                |                  | vare                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Interval Retwee                  |
| diate cause  diate cause  diate cause  diate cause  diate cause  diate cause  (a)  DUE TO  edent causes(s)  so or conditions, if any, rise to the above cause the underlying cause last.  DUE TO  SIGNIFICANT CONDITIONS ons contributing to the death but not to the disease or condition causing decorated by the condition causing decor | ath.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | seleno            |                        | ent Pa           | riare                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Interval Betwee Onset And Deat   |
| diate cause  (a)  DUE TO  DUE TO  by or conditions, if any, rise to the above cause the underlying cause last.  SIGNIFICANT CONDITIONS  ons contributing to the death but not to the disease or condition causing decorate of the disease of of the di | EADING TO DEATH  COLUMN  CALLES OF THE STATE | seleno            |                        |                  | vare                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Interval Betwee Onset And Deat   |
| diate cause  diate cause  diate cause  cedent causes (s)  so or conditions, If any, rise to the above cause the underlying cause last.  SIGNIFICANT CONDITIONS ons contributing to the death but not to the disease or condition causing decoration causing decoration (Specify)  ENT (Specify)  ENT (Specify)  ENT (Specify)  ENT (Specify)  PLACE OF INJURY  Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ath. (Home, farm, factory, street                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | city or 1         |                        | ent Pa           | riare                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Interval Betwee Onset And Deat   |
| diate cause  diate cause  diate cause  cedent causes (s)  so or conditions, If any, rise to the above cause the underlying cause last.  SIGNIFICANT CONDITIONS ons contributing to the death but not to the disease or condition causing decoration causing decoration (Specify)  ENT (Specify)  ENT (Specify)  ENT (Specify)  ENT (Specify)  PLACE OF INJURY  Month) (Day) (Year) (Hour)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ath.  (Home, farm, factory, street office bldg., etc.)  NJURY OCCURED While at Not While                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | city or 1         | rown)                  | ent Pa           | riare                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | inte<br>Ons                      |

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Supply every item of information carefully. The correct

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WITH

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To the manuscraft

BUREAU V.

SEP 30 1955

| MEDICAL                                                        | EXAM                        | NER'S                                       | CER               | LIFICA         | TE OF                        | DEAT                    | HN       | o). (2                   |
|----------------------------------------------------------------|-----------------------------|---------------------------------------------|-------------------|----------------|------------------------------|-------------------------|----------|--------------------------|
| I. PLACE OF DEATH:                                             |                             |                                             | 1                 | 2. USUAL RES   | IDENCE (HOME                 | of DECEASE              | );       |                          |
| COUNTY CANAL                                                   |                             | MARYI                                       | LAND              | STATE 7        | Carreland                    | OUNTY CAS               | race     |                          |
| OR and give nearest toy                                        |                             |                                             | H OF STAY         | CITY (If ou    |                              | imits write RURA        | L and gi | ve nearest town)         |
| 27 TOWN Westma                                                 | emle                        |                                             | years             | TOWN           | Motory                       | notes                   |          | 27                       |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS                      | · Mades                     | n't Gen                                     | 16 St.            | STREET ADDRESS |                              | If rural, give loca     | stion)   |                          |
| DECEASED:                                                      | irst) -BEN /                | 3 URBESS                                    | 1/1/              | (Last)         | 6   4. DATE<br>OF<br>DEAT    | -                       | (Day)    | (Year)<br>19             |
| 6. SEX.                                                        | WIDE (Spec                  | LE, MARRIED,<br>DWED, DIVORCE<br>ify): MAMA | D. Du             | OF BIRTH:      | 90 64                        | birthday: IF UN<br>Mont |          | Hours   Min.             |
| work done during most<br>even if retired):                     | (Give kind of of work life. | 10b. KIND OF B<br>INDUSTRY:                 |                   | of Med         | LACE (State or               | foreign country)        |          | TIZEN OF WHAT            |
| 13. FATHER'S NAMES                                             |                             | 1 1.1                                       |                   | 14. MOTHER'S   | MAIDEN NAM                   | E:                      |          |                          |
| Tohnam                                                         | ANTH                        | como                                        | 1                 | Sin            | ne The                       | ussell                  |          |                          |
| 15. WAS DECEASED EVER IN (Yes, no, or unk.) (If Yes, gi        |                             | 16. SOCIAL SECU                             | RITY No.: I       | 7. INFORMANT   | & ADDRESS:                   | 00 .                    | 58,      | madoone                  |
| service)                                                       |                             | 1220-26                                     | -7397             | Mrs. Ulo       | ie Mason                     | cheener                 | LAR      | trussista                |
| I. DISEASES OR CONDITIO                                        | NS DIRECTLY 1               | LEADING TO DE                               |                   | L CERTIFICATI  | ON                           |                         |          | NTERVAL BETWEEN          |
| Immediate cause                                                | (a)                         | Hungu                                       | eg leg i          | he ne          | 21                           | **********************  |          |                          |
|                                                                | DUE TO                      |                                             |                   |                |                              |                         |          |                          |
| Antecedent cause(s) Diseases or conditions, if                 | /1.5                        | *******************                         |                   | >>*****        |                              |                         |          |                          |
| giving rise to the above<br>stating underlying caus            | cause DUE TO                |                                             |                   |                |                              |                         |          |                          |
| II. OTHER SIGNIFICANT OF THE DEATH BUT DISEASE OR CONDITION    | NOT RELATE                  | D TO THE                                    |                   |                |                              |                         |          |                          |
| 19a. DATE OF OPERATION                                         | 1: 19b. MAJOR               | FINDING OF OP                               | ERATION:          |                |                              |                         |          | Yes No No                |
| 21a. EXTERNAL CAUSE W. PRIMARY OF CONTRIBUTION CAUSE OF DEATH. | UTING 🗆                     | INJURY HEAT H                               | ury etc.,         |                | Extinuel                     |                         | the      | (State) rel              |
| 21d. TIME (Month) (Day) OF INJURY                              | (Year) (Hour) M.            | 21e. INJURY OC<br>While at<br>work □        | Not while at work | 21f. HOW I     | Jung -                       | CUR?                    |          |                          |
| 22. I hereby certify the                                       |                             |                                             |                   |                |                              |                         |          |                          |
| find that death resu                                           | ilted from: N               | Natural causes                              | , Accide          |                | ide 🔠 , Hon<br>HIEF MEDICAL  |                         | ideterm: | ined cause   DATE SIGNED |
| James 3                                                        | 1. Tho                      | 162                                         |                   | M. D. A        | EPUTY MEDIC.<br>SSISTANT MEI | AL EXAMINER             |          | 9/12/50                  |
| 23. BURIAL, CREMATION, REMOVAL (Specify):                      | Sept ./4                    | EOF NAME OF                                 | muty L            | Thoras C       | Internal                     | Starl Who               | or count | sty Mid                  |

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Supply every item of information carefully. The correct write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Y, WITH UNFADING INK.

PLEASE WRITE PLAIN age is especially

BULEVO V. S.

8579

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 70

| 1. PLACE OF DEATH<br>COUNTY                    |                                                          |                                                               | 2. USUAL RESIDENCE             | (HOME) OF DECEASED.                             | JTV                       |
|------------------------------------------------|----------------------------------------------------------|---------------------------------------------------------------|--------------------------------|-------------------------------------------------|---------------------------|
|                                                | Carroll                                                  | MARYLAND                                                      | Maryland                       |                                                 | rroll                     |
|                                                | rporate limits, write RUR                                | AL and   LENGTH OF STAY (in this place)                       | CITY (If outside corpo<br>OR   | rate limits, write RURAL and                    | give nearest town)        |
| X TOWN Tone                                    | eytown                                                   | 7 i fe                                                        | TOWN Taneyto                   | n wn                                            | X                         |
| HOSPITAL OR INSTITUTION OR STREET ADDRES       |                                                          |                                                               | STREET<br>ADDRESS              | (If rural, give location)                       |                           |
| 3. NAME OF                                     | (First)                                                  | (Middle)                                                      | (Last)                         | 4. DATE (Montb)                                 | (Day) (Year)              |
| DECEASED                                       | Marv                                                     | Blanche                                                       | Wilt.                          | OF                                              |                           |
| (Type or Print) 5. SEX                         | 6. COLOR OR RACE                                         | 7. SINGLE, MARRIED,                                           | S. DATE OF BIRTH               | DEATH September 1 9. AGE last birthday   If und | er 20 1955                |
| Female                                         | White                                                    | WIDOWED, DIVORCED,<br>(Specify) Widow                         | Sept.23,1888                   | 66 yrs. Mont                                    | ha Days Hours Min.        |
|                                                | TION (Give kind of work                                  |                                                               | 11. BIRTHPLACE (State          |                                                 | 12. CITIZEN OF WHAT       |
| done during most of wo                         | orking life, even if retired)                            | INDUSTRY<br>OWN home                                          | Maryland                       |                                                 | COUNTRY?                  |
| 13. FATHER'S NAME                              |                                                          |                                                               | 14. MOTHER'S MAIDE             | N NAME                                          |                           |
| Jesse I                                        | Leister                                                  |                                                               | Cora Lawyer                    |                                                 |                           |
| 15. WAS DECRASED EV                            | ER IN U.S. ARMED FORCES                                  | ?   16. SOCIAL SECURITY NO.                                   | 17. INFORMANT AND              | ADDRESS                                         |                           |
|                                                | (If yes, give war or dates service)                      | none                                                          | Mrs. James Bar                 | umgardner. Tanev                                | town Md                   |
| // no '                                        |                                                          | 18. MEDICAL CE                                                |                                |                                                 | I Mar                     |
| T THOM LONG OR GO                              | ADDITIONS DIDECTLY                                       | TEADING TO DEATH                                              |                                |                                                 | INTERVAL BETWEEN          |
| 1. DISEASES OR CO                              | NDITIONS DIRECTLY                                        |                                                               |                                |                                                 | ONERT AND DEATH           |
| 1/4/                                           | (a)                                                      | Interlinal Och                                                | etnuction                      |                                                 | 15 days                   |
| Immediate                                      | cause (=)                                                |                                                               |                                | 00 × 00 0 × 000 × 0 × 0 × 0 0 0 0 0 0 0         |                           |
| giving rise to                                 | onditions, if any, (b) the above cause                   | aveinona of                                                   | uterus                         |                                                 | 12 mo                     |
| stating the ur                                 | iderlying cause last                                     |                                                               |                                |                                                 |                           |
| II. OTHER SIGNIFIC                             | CANT CONDITIONS                                          |                                                               | · T 10                         |                                                 |                           |
| Conditions contribut                           | ting to the death but not<br>e or condition causing deat | th. Hypertension                                              | - mitral Reg                   | vigilation                                      | many year                 |
| 19a. DATE OF OPER                              | RATION 19b. MAJOR I                                      | FINDINGS OF OPERATION                                         |                                |                                                 | 20. WUTOPSY?              |
|                                                |                                                          |                                                               |                                |                                                 | Yes No C                  |
| 21. ACCIDENT<br>SUICIDE<br>HOMICIDE            | (Specify) PLA<br>OF<br>INJ                               | CE (Home, farm, factory, street, office bldg., etc.)          | (CITY OR                       | TOWN) (COUNT                                    | TY) (STATE)               |
| TIME (Month) OF INJURY                         | (Day) (Year) (Hour) m.                                   | INJURY OCCURRED<br>  While at   Not While<br>  Work   At work | HOW DID INJURY O               | CCUR?                                           |                           |
|                                                |                                                          | e deceased from Syl                                           | 1955 to Seet                   | 20 1965 that I les                              | t saw the deceased        |
| 22. I nereby term                              | Ty that I accended on                                    | e deceased from                                               | , 10,, 00                      | , IV, unau I lao                                | c saw the deceased        |
| alive on SIGNATURE                             | /9 , 19.55, an                                           | d that death occurred at                                      | ADDRESS from the               | e causes and on the date                        | stated above. DATE SIGNED |
| E. Ambles                                      | - Thompso                                                | u MD                                                          | Taneylow                       | me med.                                         | 9-21-55                   |
| 23. BURIAL, CREMA<br>REMOVAL (Speci<br>BURIAL) | fv)                                                      |                                                               | V                              | LOCATION (City, town, or ed                     |                           |
| DATE REC'D BY I                                |                                                          |                                                               | Cemetery   124. FUNERAL DIRECT | Taneytown, Mary                                 | ADDRESS                   |
| SREGIT 21,                                     | 1953 Plu                                                 | ()2.1 11 11                                                   |                                | n, Taneytown, Mar                               |                           |
|                                                |                                                          |                                                               |                                |                                                 |                           |

VS. A15

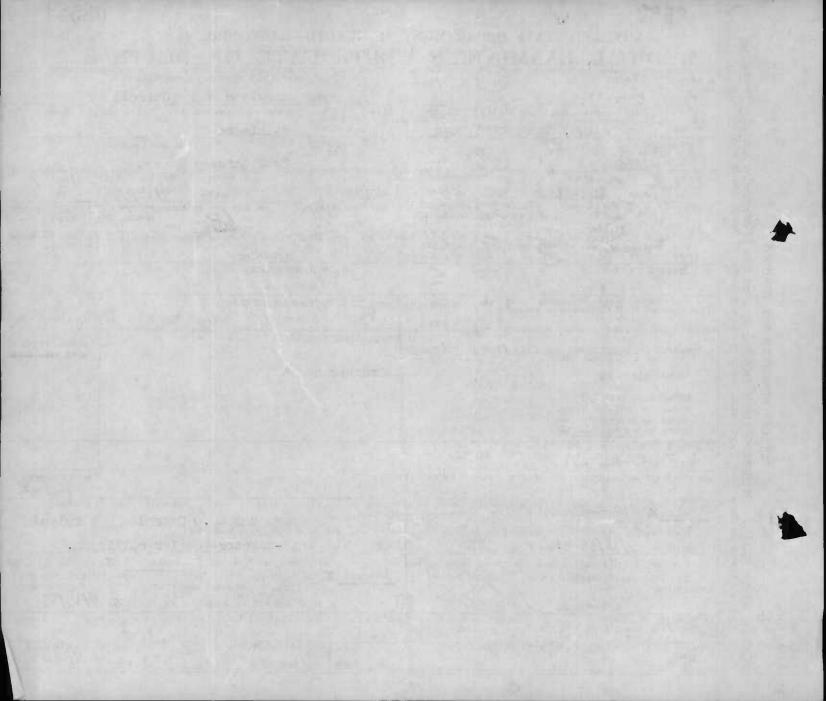
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

|                                       | MARGI | WITH UNFA                       |
|---------------------------------------|-------|---------------------------------|
|                                       |       | PLAINLY,                        |
| A A A A A A A A A A A A A A A A A A A | ah    | PLEASE WRITE PLAINLY, WITH UNFA |
| VG                                    | 2     |                                 |

| 8590                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 08584                                                                                                                                                                                                 |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| MARYLAND STATE DEPARTMENT OF H                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | TIFICATE OF DEATH No. 7.4                                                                                                                                                                             |
| I. PLACE OF DEATH:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 2. USUAL RESIDENCE (HOME) OF DECEASED:                                                                                                                                                                |
| COUNTY Carroll MARYLAND                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STATE Maryland COUNTY Carroll                                                                                                                                                                         |
| CITY (If outside corporate limits, write RURAL   LENGTH OF STAY   OR and give nearest town) (in this place)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Baltimore                                                                                                                |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET (If rural, give location) ADDRESS 2008 Barclay Street                                                                                                                                          |
| 8. NAME OF (First) (Middle) DECEASED: (Type or Print) NATHAN A. WOL                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (Last) 4. DATE (Month) (Day) (Year) OF DEATH 9/18/55 19                                                                                                                                               |
| Male RACE: WIDOWED, DIVORCED, (Specify):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | OF BIRTH: 9. AGE last birthday: IF UNDER 1 YEAR HOURS 24 HR. Wonths Days Hours Min.                                                                                                                   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Russia 934.                                                                                                                                                                                           |
| 13. FATHER'S NAME: Locof Wolf                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | 14. MOTHER'S MAIDEN NAME:                                                                                                                                                                             |
| 15. WAS DECEASED EVER IN U.S. ARMED BORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Mr. Edward Legiem - 3026 Troga Parkioa                                                                                                                                                                |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:    Cru                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Interval Betwee Onset and Deats                                                                                                                                                                       |
| II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                       |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 20. AUTOPSY? Yes □ No-1                                                                                                                                                                               |
| 21a. EXTERNAL CAUSE WAS PRIMARY Of CONTRIBUTING OF street, office bidge, etc., INJURY STREET  21d. TIME (Month) (Day) (Year) (Hour)   21e. INJURY OCCURRED                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 21c. (City or town) (County) (State)   Sandymount Rd. Carroll Maryland   21f. How pid Injury occur?                                                                                                   |
| OF INJURY 9/18/55 6240 P M. While at work at work                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Auto-tractor-trailer collision.                                                                                                                                                                       |
| 22. I hereby certify that I took charge of the remains describ                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ded above, held an Autopsy , Inspection , Inquiry , are dent , Suicide , Homicide , Undetermined cause CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. |
| 23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETER  BUYAL (Specify): 275. 2055 Charles New Constant C | na Rosedale, md                                                                                                                                                                                       |
| REG. 2 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Sol. offinion Bios -1124-26 W. North and                                                                                                                                                              |
| )wh                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                       |



correct

### CERTIFICATE OF DEATH

| 0020                                                                                                     | Reg. Dist.                                       | . No.                  |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------|------------------------|
| I. PLACE OF DEATH:                                                                                       | 2. USUAL RESIDENCE (HOME) OF DECEASED:           |                        |
| COUNTY CANAL MARYLAND                                                                                    | STATE Munland COUN                               | ITY CAMPI              |
| CITY (If outside corporate limits, write RURAL LENGTH OF STAY                                            | CITY (If outside corporate limits, write RURAL a |                        |
| OR and give/nearest town) (in this place)                                                                | TOWN / Patracent                                 | med ny                 |
| HOSPITAL OR                                                                                              | STREET (If rural give location                   |                        |
| STREET ADDRESS 66 Plana. ave                                                                             | ADDRESS 66 Penna. C.                             | Tue.                   |
| DECEASED:                                                                                                | (Last) . 4. DATE (Month) (DR)                    | 7                      |
| 6. SEX:   S. COLOR OR   7. SINGLE, MARRIED,   8. DATE O                                                  | DEATH: DEATH: P. AGE last birthday: IF UNDER 1   | EAR   IF UNDER 24 HRS. |
| RACE, WIDOWED, DIVORCED, (Specify): 1                                                                    |                                                  | ays Hours Min.         |
| USUAL OCCUPATION. Give kind of Job. KIND OF BUSINESS OR work done during most of working life, INDUSTRY: |                                                  | CITIZEN OF WHAT        |
| even if retired working the                                                                              | Carroll(2. md.                                   | 1.5.0.                 |
|                                                                                                          | 14. MOTHER'S MAIDEN NAME:                        |                        |
| Meorae W. Belosto                                                                                        | Hanne Halle                                      |                        |
|                                                                                                          | INFORMANT & ADDRESS:                             | -                      |
| Yes, no, or up(.) (If Yes, give war or dates of                                                          | M. B. Harley Wester                              | usler Mid              |
| 18. MEDICAL CERTIFICATIO                                                                                 | IN .                                             | Interval, Between      |
| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                      | Contractor                                       | Onset And Death        |
| Immediate cause (a)                                                                                      | restruc heusenhage                               | 18 hours               |
| DUE TO                                                                                                   | Caterio. Scleracio.                              |                        |
| Antecedent causes (s) Diseases or conditions, If any,                                                    | caleny. Sclarkes.                                | 1090000                |
| giving rise to the above cause stating the underlying eause last.                                        |                                                  | 0                      |
| (c)                                                                                                      |                                                  |                        |
| II. OTHER SIGNIFICANT CONDITIONS                                                                         |                                                  |                        |
| Conditions contributing to the death but not related to the disease or condition causing death.          |                                                  |                        |
| 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION                                                 |                                                  | 20. AUTOPSY ?          |
| 9                                                                                                        |                                                  | Yes No                 |
| ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.)                            | (CITY OR TOWN) (COUNTY).                         | STATE)                 |
| TIME (Month) (Day) (Year) (Hour) INJURY OCCURED While at Not While INJURY                                | HOW DID INJURY OCCUR?                            |                        |
| 22. I hereby certify/that I attended the deceased from                                                   | ,1955, to 9/17 , 1955, that I last               | caw the deceased       |
| " alih ort                                                                                               | 1115 1                                           | -                      |
| alive on, 1900, and that death occurred at                                                               | from the causes and on the date                  | stated above.          |
| De cetre Bar                                                                                             | ( Raturista 110cl                                | 4/19/11                |
| 3. BURIAL CREMATION DATE THEREOF AL NAME OF CEMEROR                                                      | Y OR CREMATORY   LOCATION (City, town, or co     | ourity) (State)        |
| Bureal Sept. 2051 Pape Cro                                                                               | 196 Cocaster Kural, West XI                      | suche Med.             |
| DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 2                                                              | 4. JUNERAL DIRECTOR                              | ADDRESS                |
| 9-16-1- 7-6-11                                                                                           | V. 9. Ma. 14. / // //                            | error Illa             |

VS. A15

MARGIN RESERVED FOR BINDING

BUREAU V. &

SEP 21 1955

BECEINED

#### MARYLAND STATE DEPARTMENT OF HEALTH

8531

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

| 1. PLACE OF DEATH-                                                                                                               | 2. USUAL RESIDENCE (HOME) OF DECEASED.                  | 1                                              |
|----------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|------------------------------------------------|
| MARYLAND MARYLAND                                                                                                                | mel cauge                                               | 4                                              |
| CITY (If outside corporate limits, write RURAL and LENGTH OF STAY (in, this, place)                                              | CITY (If outside corporate limits, write BURAL and give | nearest town)                                  |
| TOWN manchester 30 years                                                                                                         | TOWN Manufisles                                         | X                                              |
| HOSPITAL OR INSTITUTION OR I / / / / / / /                                                                                       | STREET (If rural, give location)                        | . /                                            |
| O STREET ADDRESS / O M Sample are                                                                                                | 100 Westmens                                            | ten are                                        |
| 3. NAME OF Print (Adddle)                                                                                                        | OF AIM                                                  | (Day) (Year)                                   |
| (Type or Print) UVUVIV                                                                                                           | pugling DEATH SIDE                                      | 24 1/105                                       |
| 6. SEX 6. COLOR OR RACE 7. SMALE, MARRIED. WIDOWED, DIVORCED (Specify) Manual                                                    |                                                         | Sear   If under 24 hrs.<br>Days   Hours   Min. |
| male while (Specify) manual                                                                                                      | 06/30/13 8 2 yrs.                                       |                                                |
| done during most of working life, even if retired)  10b. Kind of Rusiness or Industry                                            |                                                         | CITIZEN OF WHAT                                |
| 13. PATHER'S NAME                                                                                                                | I MOTHER'S MAIDEN NAME                                  | V.5,A                                          |
| 13. PATHER'S NAME                                                                                                                | 14. MOTHER'S BIRIDER PORT                               | 0                                              |
| 15 WAS DECRASED EVERAN U.S. ASMED FORCES 1 16. SOCIAL SECURITY NO.                                                               | 17/NFORMANT AND ADDRESS 7                               | men dit                                        |
| (Yes, no, or unknown)   (N yes, give war or days of                                                                              | 11 MORNIANI AND ADDRESS / 30 10h                        | in out again                                   |
| 18. MEDICAL CER                                                                                                                  | posterior in fundamy                                    | " Lower of                                     |
|                                                                                                                                  | ACHICATION                                              | INTERVAL BETWEEN                               |
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH                                                                              | 70 .                                                    | ONSET AND DEATH                                |
| 420,1 Caronary                                                                                                                   | Thurstons                                               | IMON.                                          |
| Immediate cause (a)                                                                                                              | A                                                       |                                                |
| Antecedent cause(s) artemore                                                                                                     | leurs                                                   | 3 wm                                           |
| Diseases or conditions, if any, (b)                                                                                              |                                                         |                                                |
| stating the underlying cause last                                                                                                |                                                         |                                                |
| (e)                                                                                                                              |                                                         |                                                |
| 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. |                                                         |                                                |
| 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION                                                                          |                                                         | 20. AUTOPSY?                                   |
| U I I I I I I I I I I I I I I I I I I I                                                                                          |                                                         | Yes No                                         |
| 21. ACCIDENT (Specify) PLACE (Ilome, farm, factory, street, SUICIDE OF office bldg., etc.) HOMICIDE INJURY                       | (CITY OR TOWN) (COUNTY)                                 | (STATE)                                        |
| TIME (Month) (Day) (Year) (Hour)   INJURY OCCURRED                                                                               | HOW DID INJURY OCCUR?                                   |                                                |
| OF INJURY  m. While at Not While Not Work  At work                                                                               |                                                         |                                                |
| 21100112                                                                                                                         | 17 Sort 216 - 55 - 171                                  |                                                |
| 22. I hereby certify that I attended the deceased from                                                                           |                                                         |                                                |
| alive on lent 20 1955, and that death occurred at 5                                                                              | : 30 Am., from the causes and on the date stat          | ted shove.                                     |
| SIGNATURE (Degree or title)                                                                                                      | ADDRESS                                                 | DATE SIGNED                                    |
| WH. Fround M.D.                                                                                                                  | Manchester, Md 9                                        | 124155                                         |
|                                                                                                                                  | RY OR CREMATORY   LOCATION (City, town, or county       | y) (State)                                     |
| REMOVAL (Specific) 9/26/55 manchest                                                                                              | a Kel Com manchester la                                 | usels ma                                       |
| DATE REC'D BY LOCAL   AMGISTRAR'S SIGNATURE                                                                                      | 24 FUNEBAL DIRECTOR                                     | ADDRESS                                        |
| REGSett 26-55 Mis. NR. Deliner                                                                                                   | Trederick Suchen Har                                    | rangela                                        |
|                                                                                                                                  |                                                         |                                                |

The correct age

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15

SEE 30 1982